June 29, 2005

EQRO Report

LTC Contractors CY 2004
AHCCCS

MERCER
Government Human Services Consulting

MMC Marsh & McLennan Companies

Contents

1. Executive Summary 1

- Background 1
- Major Conclusions Drawn from the AHCCCSA ALTCS Reviews 2
- Recommendations Made by ALTCS for Contractor Improvement 8
- Results of EQR Activity Shared with Providers, Members, and Potential Members 9
- Provision of Input of Members and Other Stakeholders into Quality Strategies of the Organizations 10

2. Purpose/Objectives of Reviews 11

- EQR Protocols Used by AHCCCSA 13
- Report Commentary 14

3. Compliance 15

- Introduction 15
- Tools (Instructions, Guidelines, Worksheets, Documents) Used by AHCCCSA in Implementing Compliance Protocol 16
- Data Gathered by AHCCCSA During the Review and Source 16
- Procedures Followed by AHCCCSA in Collecting Data to Promote Accuracy, Validity, and Reliability 17
- Conclusions Drawn by AHCCCSA (including any Quality of Care Concerns and any Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care) 18
- Compliance Review Deficiencies FY 2003 19
- Compliance Review Findings CYE 2004 24
- Summary of Combined Results and Compliance with BBA regulations 43
- Results of EQR Activity Shared with Providers, Members, and Potential Members 60
- Provision of Input of Members and Other Stakeholders into Quality Strategies of the Organizations 60

4. Performance Measures Review 61

- Review Methodology 61

- Performance Measures....62
- Results of PM Review....63

5. Performance Improvement Projects Review....68

- Goals and Objectives of PIP Review....68
- Methods....68
- Summary of Findings....69
- Strengths and Opportunities for Improvement....73
- Summary Conclusions....73

Appendix A

Regulations Crosswalks

Appendix B

AHCCCSA Review Documents

Appendix C

Documents Reviewed List

1

Executive Summary

Background

Mercer Government Human Services Consulting (Mercer) has written this External Quality Review (EQR) report for the Contract Year Ending 2004 (CYE 2004) in fulfillment of the requirements of 42 CFR Parts 433 and 438 of the Balanced Budget Act of 1997 (BBA). The Arizona Health Care Cost Containment System Administration (AHCCCSA) has chosen to conduct their own review of their Arizona Long-Term Care Services (ALTCS) Contractors' compliance with Federal and State of Arizona (State) structural and operational standards. Under the Federal Regulations, three required activities must be reviewed and reported:

- the review of compliance with structural and operational standards,
- the validation of performance measures (PMs), and
- the validation of performance improvement projects (PIPs).

As specified under Federal law, AHCCCSA has provided the results of its compliance review and the other two required activities to Mercer, as the External Quality Review Organization (EQRO), to compile, analyze, and evaluate the aggregated information for an overall EQR report for six of the seven ALTCS elderly/physically disabled (EPD) Contractors. Pursuant to §438.350, the information that Mercer received to compile the report must have been obtained by AHCCCSA through methods consistent with protocols specified by the Centers for Medicare & Medicaid Services (CMS). Further, AHCCCSA, in conducting its activities, must have reported on the objectives, technical methods of data collection and analysis, description of the data obtained, and conclusions drawn

from each activity while identifying and assessing quality of care concerns revealed by the activities. Mercer's EQR report incorporates findings from all activities presented to us by AHCCCSA and includes an assessment of the strengths and weaknesses of the activities with respect to quality, timeliness, and access of care provided by the six ALTCS Contractors:

- Cochise Health System (Cochise Health),
- Evercare Select Health Plan (Evercare Select)
- Mercy Care Plan,
- Pima Health System (Pima Health)
- Pinal/Gila County Long-Term Care (Pinal/Gila County), and
- Yavapai County Long-Term Care (Yavapai County).

During the processes of review, analysis, and reporting of the EQR activities for this report, Mercer did not review ALTCS Contractors' materials, re-calculate any measurement results, validate any of the Contractors' PMs or indicators for the PIPs, validate any encounter data, or complete an actual compliance review or information systems' assessment. Mercer's report conclusions are based solely upon the findings of quality review activities, as presented to us by AHCCCSA.

AHCCCSA has demonstrated in the review materials that they required each Contractor to develop a Corrective Action Plan (CAP) for each deficiency identified from their Operational and Financial Review (OFR). The CAP was reviewed and if it was not satisfactory, additional requirements for correction were requested. If the CAP was satisfactory, it was approved after review.

Major Conclusions Drawn from the AHCCCSA ALTCS Reviews

A review of the AHCCCSA Contract with the ALTCS Contractors revealed that the contract was compliant with BBA regulations and clearly required the Contractors to comply with 42 CFR Parts 433 and 438. AHCCCSA identified regulations for which review still needs to be done in CYE 2005 and they completed a crosswalk for each Contractor of regulations covered or not covered during the CYE 2004 review. The listing of these regulations was condensed by Mercer, and a grid identifying those regulations not yet covered during a review with each Contractor was developed and can be found in Appendix A.

For those regulations reviewed during CYE 2004, the following table summarizes AHCCCSA's major findings.

AHCCCS' Major Conclusions in Relation to Assessment of Quality of Care Concerns

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
Enrollee Rights	**Enrollee Right to Information (General and Specific)** ▪ There was adequate assessment of languages spoken among all Contractors and all of them translated some or all of their member materials into Spanish, even when the population did not quite meet the 5 percent requirement. ▪ Adequate translation services and the ability to track utilization were demonstrated. ▪ AHCCCSA has determined that information requirements, both general and specific, were met. ▪ Member rights and responsibilities related to grievance, appeals, and fair hearing information was supplied to members in Notices of Actions (NOAs) for any denials, suspensions, or reductions in services. ▪ Advanced Directives issues are scheduled to be reviewed during CYE 2005. **Emergency Services/Post-Stabilization Information** ▪ These regulations will be reviewed for compliance during CYE 2005. **Grievance, Appeal, and Fair Hearing Information** ▪ The review findings determined that the member rights and responsibilities related to grievance, appeals, and fair hearing information was supplied to members in NOAs. Only one Contractor had deficiencies and they were required to implement a CAP.
Quality Assessment and Performance Improvement	
Access Standards	**Availability of Services/Timely Access to Services/Delivery Network** ▪ The review identified that each Contractor was required to file a Network Development and Management Plan as well as an annual evaluation of the plan. ▪ Based on network assessments, modifications to expand some provider services were made by two Contractors. ▪ There was adequate access to Home- and Community-Based Services (HCBS) services as no wait lists existed for HCBS except for one Contractor. ▪ All Contractors, except one, monitored routine, specialist, and emergency appointment times and these were within standards. One Contractor was deficient in monitoring routine and emergency appointment times related to behavioral health (BH). ▪ Primary care and specialty physician appointment and office wait times were in compliance with required standards by all

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
	Contractors. ▪ One Contractor was delayed in providing home modifications within State timeliness standards. **Cultural Competency of Services** ▪ Each Contractor filed a Cultural Competency Plan with AHCCCSA which met State requirements and conducted an annual evaluation of the plan. ▪ All Contractors took action when the evaluation identified a need. ▪ All Contractors had an orientation and on-going education program for employees and providers about providing culturally-competent services. ▪ Members were provided information on how to access culturally related materials and translation services through orientation programs, enrollment materials, and newsletters. ▪ There were minimal (3) complaints relating to cultural competency issues during CYE 2004. ▪ Only one Contractor was required to follow-up with a CAP to address on-going education of members related to culturally-competent issues.
Coordination and Continuity of Care	**Coordination and Continuity** ▪ All Contractors made 'best effort' attempts toward conducting initial assessments of health care needs of members. ▪ Efforts were directed toward assuring that members were in the most integrated/least restrictive setting. ▪ All Contractors were identified as ensuring members received uninterrupted services and supports in the BH arena. ▪ In the area of HCBS, non-provision of authorized services monitoring was done to identify service access issues. ▪ Two areas of deficiencies were demonstrated: – difficulties coordinating care among primary care physicians (PCPs) and other involved agencies and parties, and – lack of systems to ensure timely and appropriate planning for Transitional Program members in nursing facilities. **Special Needs Requirements** ▪ Every ALTCS member is assigned a PCP along with a Case Manager. ▪ Case Managers conduct a comprehensive assessment of every ALTCS member within 12 business days of enrollment. **Privacy Protection** ▪ Privacy requirements will be reviewed during CYE 2005.
Coverage and	**Authorization of Services**

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
Authorization of Services	▪ All Contractors had written policies and procedures for monitoring and evaluating utilization of services. Annual Utilization Management Evaluation and Work Plans submitted to, reviewed by, and approved by AHCCCSA. ▪ Standardized criteria were used for decision-making and all but one Contractor had inter-rater reliability policies. ▪ Four Contractors were identified as taking action when criteria were not being applied consistently. ▪ Concurrent review was done to assess for medical necessity and for appropriateness of level of care. ▪ For HCBS, under-utilization of services, such as pharmacy and over-utilization of emergency services, was monitored with action being taken when issues were identified. ▪ Five Contractors had prior authorization decisions conducted in a timely manner. **Emergency and Post-Stabilization Services** ▪ These regulations were not evaluated during the CYE 2004 contract year and will be addressed in the CYE 2005 review.
Structure and Operation Standards	**Provider Selection** ▪ All Contractors had appropriate policies and procedures for credentialing and recredentialing related to individual providers. ▪ Two Contractors did not have credentialing/recredentialing provisions for temporary situations or for facilities. ▪ Two Contractors did not validate licensing of providers every three years. ▪ Five Contractors did check to determine if the providers were in compliance with Federal and State requirements. ▪ All Contractors used member complaint information and quality improvement (QI) information for consideration in recredentialing decisions. **Enrollment and Disenrollment** ▪ Not reviewed as this is not applicable as enrollment is mandatory and the Contractor is not allowed to disenroll members. **Subcontractual Relationships and Delegation** ▪ These standards were not evaluated during the CYE 2004 contract year and will be reviewed during CYE 2005.
Measurement and Improvement Standards	**Quality Program** ▪ Annual Quality Management Evaluation and Work Plans submitted to, reviewed by, and approved by AHCCCSA. **Practice Guidelines** ▪ All Contractors had adopted practice guidelines based on national and community standards. ▪ One Contractor did not have a complete set of guidelines.

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
	▪ Five Contractors disseminated guidelines to their providers. **Quality Assurance Program Initiative (QAPI Program)** ▪ Quality Improvement Project Proposals (CYE 2003) and Quality Improvement Project Interim Reports (CYE 2002) for each Contractor were reviewed by AHCCCSA. ▪ PMs: – HbA1c testing; ▫ followed Health Plan Employer Data and Information Set® (HEDIS®) specifications; ▫ five Contractors met AHCCCSA's minimum performance standards for the current measurement period; ▫ three Contractors' results increased from the prior to the current measurement period (none of which were statistically significant); and ▫ three Contractors' results declined from the prior to the current measurement period (one of which was statistically significant). – Eye Exams: ▫ all Contractors met HEDIS® specifications; ▫ five Contractors met AHCCCSA's minimum performance standards for the current measurement period; and ▫ two Contractors met AHCCCSA's goal in the current measurement period. – Lipid Screening: ▫ all Contractors met HEDIS® specifications; ▫ six Contractors met AHCCCSA's minimum performance standards for the current measurement period; and ▫ six Contractors' results increased from the prior to the current measurement period (one of which was statistically significant). – Initiation of HCBS Waiver Services: ▫ followed AHCCCSA's own internal specifications; ▫ five Contractors met AHCCCSA's minimum performance standards for the current measurement period; ▫ four Contractors' results increased from the prior to the current measurement period (one of which was statistically significant); and ▫ two Contractors' results declined from the prior to the current measurement period (neither of which was statistically significant).

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
	▪ PIPs: – Four of the six Contractors had statistically-significant improvement in one of the PIP indicators (HbA1c testing) and three of the six had significant improvements in the other (HbA1c > 9.5 percent) – The strength of this PIP was AHCCCSA's standardization. The following components were standardized by AHCCCS: ▫ selection of topic; ▫ development of study questions; ▫ identification of indicators; ▫ specification of indictors, including data collection processes and numerator and denominator construction; ▫ re-measurement processes; and ▫ data analyses for both baseline and re-measurement. – In addition, AHCCCS made recommendations to Contractors regarding possible quality improvement interventions, based on a review of current health care literature.
Health Information Systems Standards	▪ All Contractors were determined to have reasonable data rates between expected and observed data submissions. ▪ Data validation study results were evaluated and it was determined that the Contractors take measures to improve the submission of complete, timely, and accurate data. ▪ Each Contractor had an Encounter Submission Tracking Report (ESTR) to link claims to an adjudicated or pended encounter returned to Contractor. ▪ Each Contractor tracked encounter submission volume sent to AHCCCSA to identify possible omissions.
Grievance System	**Grievances/Appeals/Fair Hearings** ▪ All Contractors had written grievance, appeals, and fair hearing policies and procedures that comply with regulations, with the exception of one Contractor whose policies did not cover expedited appeal situations. ▪ All Contractors had a process for reviewing and evaluating complaints and allegations and thoroughly investigated facts gathered from all parties. ▪ CAPs to reduce/eliminate likelihood of a complaint issue reoccurring were conducted by contractors and implemented appropriate interventions and did incorporate successful interventions into a Quality Management (QM) program. ▪ Evidence was presented that demonstrated that the Contractors both acknowledged receipt of grievances and appeals as well as issued decisions in a timely manner. Professionals who had appropriate clinical expertise and who were not involved in any previous decision reviewed the appeals.

BBA Category	Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care
	▪ Two Contractors were only allowing members a 15 day appeal. ▪ Four Contractors had difficulty calculating correct appeal dates for Home- and Community-Based Services (HCBS). ▪ BBA regulations in this area will be more extensively reviewed during CYE 2005 for four of the Contractors.

Recommendations Made by ALTCS for Contractor Improvement

Compliance Review

For most areas of non-compliance with BBA regulations, AHCCCSA made recommendations to correct the deficiencies. All Contractors were required to submit CAPs. These plans were reviewed by AHCCCSA. If they were not specific enough, AHCCCSA required the Contractor to modify the CAP. Most areas of recommendation were related to needed policy updates, improvement in monitoring activities, expansion of services, and refinement of information given to members.

PMs

The PM covered two areas, Diabetes Care and HCBS. Diabetes Care includes HbA1c testing, lipid screening, and eye exams. All Contractors who did not meet the minimum performance goal were required to write a CAP.

Diabetes Care

AHCCCSA identified several areas for improvement:

- AHCCCSA is considering increasing their minimum performance standards and goals to encourage Contractors to improve their processes.
- AHCCCSA is currently providing QI strategies to the Contractors to better aid them in improving the overall quality of their diabetes management program. Such strategies include automated telephone reminders to patients reminding them about needed tests, case management/disease management follow-up by a nurse, and culturally sensitive information, such as instructions on ethnic diabetic food preparation.
- Up to 80 percent of ALTCS members are dually enrolled (Medicare and Medicaid), and AHCCCSA does not receive complete encounter information for Medicare covered services. However, AHCCCSA is working with the Health Services Advisory Group (HSAG) to address data issues and has managed to obtain, through HSAG, Medicare fee-for-service (FFS) data.

- AHCCCSA realizes that there needs to be better data collection to capture members enrolled in Medicare Advantage plans, since about 25 percent of ALTCS' EPD members have joined these plans and their information is not being captured by either AHCCCSA or HSAG, which could skew results. In fact, there is some evidence that compliance results would change by as much as 25 percent if the Medicare Advantage plans' data was included.

HCBS

AHCCCSA has made some changes to its program, including refining their methodology for evaluation of the delivery of HCBS. For example, encounter data is now being utilized, whereas previously the review only utilized chart review. Also, certain members are now excluded from the study (such as those who refused services or who were in a hospice facility) but were included in the last study.

The AHCCCSA report documented that there may have been data problems with one of the ALTCS Contractors, Evercare Select, since their results decreased significantly from the year before.

PIPs

AHCCCS has a well thought out program for selecting PIP topics, establishing baseline, and remeasurement processes to determine improvement. AHCCCS also takes care to specify, in detail, the processes and procedures that Contractors should follow when collecting data. For five of the six Contractors, AHCCCSA found that Contractors had maintained or improved their performance and would need to continue their current levels of performance to demonstrate sustained improvement. AHCCCSA requires a full report of the interventions in CYE 2005. The remaining plan did not demonstrate improvement in either indicator and was required by AHCCCSA to submit a plan to revise, replace, and/or initiate new interventions to improve performance of both indicators.

Results of EQR Activity Shared with Providers, Members, and Potential Members

It is unclear exactly what information, if any, has been shared with providers, members, and potential members, as specific information relating to the results of any EQR activity was not provided by AHCCCSA. There was indication that results of some member and provider surveys may have been shared through venues, such as newsletters and with the Member/Council, but the exact specificity of information shared is unknown.

AHCCCS has presented the six ALTCS Contractors with the results of performance measurement (baseline and first remeasurement) related to the diabetes PIPs.

Provision of Input of Members and Other Stakeholders into Quality Strategies of the Organizations

Information about the provision of input of members and other stakeholders into the quality strategies of each of the Contractors or of ALTCS as a whole was not presented to Mercer so it can not be commented on in this report.

2

Purpose/Objectives of Reviews

For the three mandated EQR activities conducted by AHCCCSA, the overall goal of review activities was to assess each Contractor's conformance with the BBA regulations related to areas of compliance, PIPs, and PMs. For each of these areas, there were multiple objectives for the totality of review activities performed by AHCCCSA, as illustrated in the following table.

Activity and Review Area	Objectives
Compliance Review	
Member Rights and Protections	▪ To identify if ALTCS Contractors are disseminating required information in a format that is easily understood and culturally-relevant to members that informs them of their rights, such as benefits, Advance Directives, access to care, and meets grievance systems and administrative hearing process requirements.
Access Standards	▪ To identify if ALTCS Contractors maintain an adequate provider network that meets the unique health care needs of its members. ▪ To determine if health care services provided are accessible, timely, coordinated, culturally-competent, and meet the needs of special high-risk populations. ▪ To identify whether ALTCS Contractors have adequate coverage and authorization mechanisms and provide coverage and payment for emergency and post-stabilization services.
Structure and Operation Standards	▪ To identify the processes ALTCS Contractors conduct to:

Activity and Review Area	Objectives
	– select and contract with their health care providers; – request disenrollment of a member; and – contract with, monitor, and evaluate their subcontractual relationships and delegation activities. ▪ To determine if the above processes comply with BBA regulations.
QAPI Standards	▪ To identify whether ALTCS Contractors' clinical practice guidelines are: – based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; – considers the needs of members; – adopted in consultation with contracting health care professionals; – disseminated to all affected providers and, upon request, to members and potential members; and – utilized in the decisions for utilization management (UM), member education, coverage of services, and other areas to which the guidelines apply. ▪ To determine if ALTCS Contractors' QAPI programs: – are comprehensive; – include mechanisms to detect both under- and over-utilization; – are evaluated annually; and – ensure that evaluation findings are incorporated into the program to improve future practices. ▪ To determine if ALTCS Contractors have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. ▪ To determine if ALTCS Contractors have a mechanism to monitor whether care is provided in a culturally-competent manner.
Grievance System Standards	▪ To identify whether ALTCS Contractors have a grievance system in place that includes a grievance process, an appeals process, and access to the State's administrative fair hearing system. ▪ To ensure that established processes meet BBA requirements. ▪ To determine if the NOAs and appeals resolution contain required information and were sent

Activity and Review Area	Objectives
	timely for both standard decisions and expedited decisions. ▪ To evaluate whether the grievance system's recordkeeping and reporting requirements were met by ALTCS Contractors.
Validation of PIPs	▪ Review the conduct of the diabetes management PIPs, including topic selection process, study questions and indicators, identified population and sampling methods, data collection procedures, improvement strategies, process for re-measurement and findings of re-measurement. ▪ Summarize the results of the individual ALTCS contractor PIPs to date.
Validation of PMs	▪ To evaluate the accuracy of PMs reported by the ALTCS Contractors. ▪ To determine the extent to which selected PMs are calculated according to specifications established by the State.

EQR Protocols Used by AHCCCSA

To conduct their EQR review activities, AHCCCSA utilized a variety of protocols consistent with common managed care and quality industry practices in widespread use today. Their primary activities were:

- on-site OFR;
- review of clinical evidence in the selection of quality indicators;
- validation of PMs, including validation of encounter data;
- review of enrollment, benefits, and member informational materials;
- review of Member/Provider Council correspondence; and
- request of the following critical documents from Contractors:
  - program components annual evaluations,
  - subcontracts,
  - provider and member surveys and results,
  - physician incentive plan reports,
  - significant change in Contractor ownership or staffing,
  - quarterly grievance reports,
  - hearing files reports,

- case management plans,
- provider network changes,
- encounter data transmissions, and
- member placement changes.

A listing of all documents reviewed by Mercer in compiling this EQR report can be found in Appendix C.

Report Commentary

Findings from all the above reports/materials/surveys/data submitted to AHCCCSA by the Contractors were not made available to Mercer. Documentation of the findings of three of the above items — the OFR, the PMs, and the PIPs — was provided to Mercer. In writing this EQR report, only review activity findings that were reported to Mercer are included. The primary review tool used by AHCCCSA, the OFR, can be found in Appendix B. AHCCCSA standards closely followed CMS protocols for PM and PIP activities. AHCCCSA provided Mercer with a crosswalk for each Contractor that identifies the individual BBA regulations and whether or not the State review covered the regulation in CYE 2004 or whether the regulation still needs review in CYE 2005 (see Appendix A for a listing by Contractor of regulations AHCCCSA identified as still needing review).

.

3

Compliance

Introduction

AHCCCS conducted an oversight compliance review of each of the six Contractors during CYE 2004. The review team consisted of the Division of Health Care Management (DHCM) ALTCS Manager, ALTCS Operations and Compliance Coordinators, the ALTCS Financial Manager, the Financial Program Compliance Auditor, BH staff, Clinical QM and Case Management personnel, representatives from the Office of Legal Assistance, and a Medical Director. The specific purposes of the review were to:

- identify compliance with CMS requirements specific to the 1115 Waiver;
- identify compliance with contract, AHCCCS policies, and State Administrative Code;
- determine Contractor operational compliance with their own policies and procedures;
- identify potential improvement opportunities;
- provide technical assistance, when needed; and
- identify noteworthy performances and accomplishments.

Tools (Instructions, Guidelines, Worksheets, Documents) Used by AHCCCSA in Implementing Compliance Protocol

The tools provided to Mercer to gather aggregated data from the Compliance section of the EQR review included:

- a copy of the ALTCS EP/D contract for CYE 2004 (October 1, 2003, through September 30, 2004);
- a blank copy of the ALTCS Member Handbook Checklist dated November 22, 2004;
- a blank copy of the Network Development and Management Plan Evaluation Annual Update;
- AHCCCSA OFR results for CY 2004 for all six ALTCS Contractors, and
- various approval notices of Contractor document reviews by AHCCCSA.

Copies of documents related to the actual review process can be found in Appendix B.

Additional Data Gathered by AHCCCSA during the Review and Source

As part of their quality review of Contractors during CYE 2004, AHCCCSA evaluated policies and procedures, conducted grievance and appeals and case management file reviews, checked for presence of provider surveys, and reviewed provider files for credentialing and recredentialing data. By contract, AHCCCSA also required Contractors to submit a variety of reports to them on a periodic basis. Information provided in the AHCCCSA OFR and in Contractor correspondence demonstrated that AHCCCSA was in receipt of some of these materials. Examples include, but are not limited to:

- Encounter Data,
- Network Development and Management Plans,
- Cultural Competency Plans,
- Member Handbook,
- Marketing/Enrollment/Informational Materials,
- Member/Provider Council Plan,
- Member/Provider Council Agendas and Minutes,
- Contractor CAPs,
- Subcontractor Contracts, and
- Annual Member Survey.

The following materials were identified in the AHCCCSA ALTCS contract as being required for submission by Contractors:

- Network Summary with Unexpected or Material Changes;
- Quarterly Grievance Reports;
- Requests for Hearing Files;
- Institutional Placement Outside the State;
- Quarterly Hospital Inpatient Showing;
- Comprehensive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Plan;
- Quarterly EPSDT Progress Report;
- Monthly Pregnancy Termination Report; and
- Semi-annual Report Pregnant Women HIV/AIDS Positive.

AHCCCSA conducted a review, made recommendations, and gave approval to the following additional documents for all Contractors:

- Annual Quality Management Evaluation (CYE 2003) and Work Plan (CYE 2004),
- Annual Utilization Management Evaluation (CYE 2003) and Work Plan (CYE 2004),
- Annual EPSDT/Dental Plan (CYE 2004),
- Annual Maternity Care Plan (CYE 2004),
- Annual Behavioral Health Plan (CYE 2004),
- Quality Improvement Project Proposal (CYE 2004), and
- Quality Improvement Project Interim Report (CYE 2003).

Data used in the Compliance section of the EQR report included results from the OFR and information from the Quality Management Work Plan and Evaluation.

Procedures Followed by AHCCCSA in Collecting Data to Promote Accuracy, Validity, and Reliability

AHCCCSA reported that they conducted these specific review procedures in conducting their EQR activities:

- On-site Review with Staff Interviews (OFR);
- Protocol/Guideline Reviews:
  - Policies and Procedures,
  - Practice Guidelines, and
  - CAP Reviews;

- File Reviews:
  - Grievance and Appeals Files,
  - UM Authorization Files,
  - Credentialing and Recredentialing Files, and
  - Case Management Files;
- Log Reviews:
  - Transportation Time Standards,
  - BH Appointment Wait Standards, and
  - HCBS Waiting Lists;
- Surveys:
  - Physician Accessibility Survey Tool, and
  - Member Satisfaction Survey Tool;
- Materials Review
  - Member Handbook,
  - Provider Manual,
  - Employee Orientation Program,
  - Employee Education Program, and
  - Member Enrollment Packages;
- Newsletter Reviews
  - Member Newsletters, and
  - Provider Newsletters; and
- Minutes Reviews
  - Regional Behavioral Health Authority (RBHA) Minutes (for BH), and
  - Member/Provider Council Meeting Minutes.

Conclusions Drawn by AHCCCSA (including any Quality of Care Concerns and any Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care)

Federal requirements for Medicaid Managed Care mandate a number of areas be included in the final EQRO report. These areas are addressed in this section of the compliance review findings:

- an assessment of the degree to which each Contractor effectively addressed the recommendations for QI, as made during the previous year's EQR;
- comparative information about all Contractors;
- recommendations for improving the quality of the services furnished by each Contractor; and
- a detailed assessment of each Contractor's strengths and weaknesses with respect to quality of the health care services furnished to AHCCCS members.

Comparative information about these required elements are outlined in the following two tables for 1) deficiencies identified during the CYE 2003 review and 2) the findings for the CYE 2004 review. A copy of a crosswalk completed by AHCCCSA outlining the status of their actual review of the BBA regulations is contained in Appendix A. The crosswalk identifies those regulations by statute which AHCCCSA reviewed in CYE 2004 and those still needing to be completed in CYE 2005. To give further clarification and for comparative purposes, Mercer has supplied an additional form in Appendix A with the actual verbiage of the regulations which will be reviewed in CYE 2005 for each individual contractor.

Compliance Review Deficiencies FY 2003

As part of their OFR of their Contractors, AHCCCSA conducted a specific review and analysis of CAPs completed in areas of deficiency previously identified in the CYE 2003 review. The first table presented below summarizes AHCCCSA's findings related to the status of the corrective action during the CYE 2004 review, identifies any outstanding deficiencies, and provides **recommendations** made by AHCCCSA. If there were no corrective actions required, **NCA** for 'No Corrective Actions' has been placed in the appropriate section. A finding is labeled AC (acute care), BH, or HCBS when information related to a review finding specific to that area was identified.

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
Member Rights	**Member Right to Information (General and Specific)** ▪ Does assess the non-English	**Member Right to Information (General and Specific)** NCA	**Member Right to Information (General and Specific)** ▪ Does conduct Member Rights and	**Member Right to Information (General and Specific)** NCA	**Member Right to Information (General and Specific)** ▪ Information related to availability of	**Member Right to Information (General and Specific)** ▪ In-services were conducted for staff

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
	language needs of the population. ▪ Has obtained interpreter services and has educated providers and employees on how to obtain interpreter services. **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** Does provide reasons for denial, reduction, suspension, or termination of services in a commonly understood language.	 **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** ▪ Reason for Action in Notice not stated in understandable language.	Responsibilities in-services and monitors documents prior to being sent to members. ▪ On-going cultural competency information is not being provided to members. **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** NCA	 **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** NCA	interpretation and translation services are included in Member Handbook and Member Newsletters. ▪ NOAs are specific to the member. **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** NCA	regarding NOA information requirements. ▪ Monitoring of NOAs was done. ▪ 100 percent of reviewed forms were in compliance. **Emergency Services/Post-Stabilization Information** NCA **Grievance, Appeal, and Fair Hearing Information** NCA
QAPI Note: Measurement and Improvement Standards are addressed in following chapters.	**Access Standards** ▪ Monitoring of members' wait times is now being conducted through member surveys and through the complaint system tracking. Follow-up is	**Access Standards** ▪ Wait times are not longer than 45 minutes. ▪ Transportation standards were met.	**Access Standards** NCA	**Access Standards** NCA	**Access Standards** NCA	**Access Standards** ▪ Eliminated waiting list for HCBS by contracting with additional Assisted Living Providers. Instituted office wait time monitoring

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
	done on any provider receiving three complaints. **Coordination and Continuity of Care** For BH, a procedure to assess whether referrals for services are being completed within three days of the request for services has been implemented. **Coverage and Authorization of Services** ▪ Dates of authorization denials are now on home modification services requests. ▪ Policy to outline mechanisms used to apply criteria and monitor consistency with concurrent review decision-making still needs written. ▪ **Develop a policy to outline mechanisms used to apply criteria and monitor consistency with**	**Coordination and Continuity of Care** ▪ Member and family involvement in treatment planning process remains deficient. **Coverage and Authorization of Services** ▪ Achieved full compliance related to medical necessity determination for BH services.	**Coordination and Continuity of Care** NCA **Coverage and Authorization of Services** ▪ Has an acceptable method for determining medical necessity for BH services.	**Coordination and Continuity of Care** NCA **Coverage and Authorization of Services** NCA	**Coordination and Continuity of Care** NCA **Coverage and Authorization of Services** NCA	practices. **Coordination and Continuity of Care** ▪ Has an acceptable method for determining member and family involvement in treatment planning process. **Coverage and Authorization of Services** ▪ Has an acceptable method for determining medical necessity for BH services. ▪ Prior authorization and concurrent review policies revised to include the writing of a CAP for instances of inconsistent application of authorization criteria. ▪ **Suggestion to increase specificity of action to be taken for instances of inconsistent application of**

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
	concurrent review decision-making needs written. **Quality Program** NCA **Structure and Operation Standards** NCA **Health Information Systems Standards** ▪ Health information system tracking of	**Quality Program** NCA **Structure and Operation Standards** ▪ Results of case management program monitoring is being done and improvement strategies address deficiencies. ▪ Revised contracts to require licenses, surveys, and substantiated complaints be submitted to AHCCCSA. **Health Information Systems Standards** ▪ Encounter areas of deficiency were	**Quality Program** NCA **Structure and Operation Standards** ▪ Revised contracts to require licenses, surveys, and substantiated complaints be submitted to AHCCCSA. ▪ Conduct monitoring of compliance with licensure, surveys, and substantiated complaints. **Health Information Systems Standards** NCA	**Quality Program** NCA **Structure and Operation Standards** NCA **Health Information Systems Standards** NCA	**Quality Program** ▪ QM has representation on the Provider Member Council. ▪ Data utilized for QI efforts are reviewed and evaluated. **Structure and Operation Standards** ▪ Revised contracts to require licenses, surveys, and substantiated complaints be submitted to AHCCCSA. ▪ Conduct monitoring of compliance with licensure, surveys, and substantiated complaints. **Health Information Systems Standards** ▪ Does submit complete, accurate,	**authorization criteria.** **Quality Program** NCA **Structure and Operation Standards** ▪ Revised credentialing/ recredentialing processes to ensure that physician assistants are being supervised by a licensed medical doctor and that advanced practice nurses are working in collaboration with physicians. **Health Information Systems Standards** NCA

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
	encounters and linkage to claims has been fixed. ▪ Deleted encounters are now logged.	corrected. ▪ Reported information system data is reviewed for accuracy, completeness, logic, and consistency. ▪ Evaluation processes are clearly documented.			and timely encounter data to AHCCCSA 96 percent of the time.	
Grievance and Appeals	▪ Acute care grievance and appeals dates are now calculated correctly on the Member Rights and Responsibilities form. But, case managers occasionally still are miscalculating HCBS grievance and appeal dates. ▪ **A schedule of dates to assist in calculating grievances and appeals timelines was given to the Contractor.**	▪ Miscalculating the grievances and appeals dates. ▪ Grievances are acknowledged within five days. ▪ Grievance decisions are rendered within 30 days of receipt.	NCA	▪ Revised grievance system policies. ▪ Conducted training. ▪ More closely monitored forms for timely notification, specific reason of intended action, use of commonly understood language, and correct date calculations.	▪ Acknowledgement of receipt of grievances is done within the five-day timeframe. ▪ Timely notification to members for services that were denied, reduced, suspended, or terminated were correct 93 percent of the time. ▪ Dates of notification calculations AC notices were correctly done 100 percent. ▪ Dates of notification calculations of HCBS NOAs were correctly done 65 percent. ▪ 25 percent of the notices were sent to	NCA

2004 Analysis of Corrective Action from CYE 2003 Review Deficiencies						
BBA AREAS	**Cochise Health**	**Evercare Select**	**Mercy Care Plan**	**Pima Health**	**Pinal/Gila County**	**Yavapai County**
					members using outdated letters. ▪ **Case management training should be done on calculating dates correctly and use of correct forms.**	

Compliance Review Findings CYE 2004

The following table represents the strengths and weaknesses — the positive findings, deficiencies, and **recommendations —** compiled for the CYE 2004 EQR by AHCCCSA. It uses the same abbreviations AC, BH, and HCBS as in the table above for the different specialized care areas. CYE 2005 in the following table means that the area will be reviewed during CYE 2005. When deficiencies were identified by AHCCCSA, each Contractor was required to submit a CAP for AHCCCSA review and approval. One Contractor (Evercare Select) was required to submit a second CAP as the first was insufficient in detail.

Findings and Recommendations Made by AHCCCSA for Contractor Improvement in Relation to Assessment of Quality of Care Concerns and Assessment of Strengths and Weaknesses with Respect to Quality, Timeliness, and Access of Care

CYE 2004

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
Enrollee Rights	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ All materials translated	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ Hired Spanish	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ Hired Spanish	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ Contract signed with	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ All materials translated	**Enrollee Right to Information** ▪ Adequate assessment of languages spoken. ▪ Hired Spanish

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	into Spanish as result of the assessment of language needs. ▪ Had educated members, providers, and staff about availability and accessibility of interpretation services. ▪ Translations services were provided including sign language. ▪ Had mechanism to track utilization of translation services. ▪ Members were informed of their rights through the Member Handbook. ▪ On-going education given to employees and providers.	speaking case managers as result of the assessment of language needs. ▪ Translates written materials into Spanish. ▪ Had educated members, providers, and staff about availability and accessibility of interpretation services. ▪ Translations services were provided. ▪ Had mechanism to track utilization of translation services. ▪ Review of enrollment materials determined that members received instruction about obtaining translation and interpretive services. ▪ HCBS — discharge potential and care options not adequately discussed with members.	speaking case managers as result of the assessment of language needs. ▪ Translates written materials into Spanish. ▪ Had educated members, providers, and staff about availability and accessibility of interpretation services. ▪ Translations services were provided including sign language. ▪ Had mechanism to track utilization of translation services.	Russian language interpreter as result of the assessment of language needs. ▪ Translates written materials into Spanish and Russian. ▪ Had educated members, providers, and staff about availability and accessibility of interpretation services. ▪ Translations services were provided, including sign language. ▪ Had mechanism to track utilization of translation services.	into Spanish as result of the assessment of language needs. ▪ Had educated members, providers, and staff about availability and accessibility of interpretation services. ▪ Translations services were provided. ▪ Had mechanism to track utilization of translation services.	speaking case managers as result of the assessment of language needs. ▪ Translates some written materials into Spanish (not required as LEP language group does not meet 5 percent or 1,000). ▪ Had not educated members, providers, and staff about availability and accessibility of interpretation services, including sign language services. ▪ **Must educate providers and employees on how to obtain interpreter services.** ▪ Translations services were provided, including sign language ▪ Had mechanism to track utilization of translation services.
	Emergency Services/ Post-Stabilization Information CYE 2005	**Emergency Services/ Post-Stabilization Information** CYE 2005	**Emergency Services/ Post-Stabilization Information** CYE 2005	**Emergency Services/ Post-Stabilization Information** CYE 2005	**Emergency Services/ Post-Stabilization Information** CYE 2005	**Emergency Services/ Post-Stabilization Information** CYE 2005

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	Grievance, Appeal, and Fair Hearing Information ▪ In compliance with all but two Member Rights and Responsibilities notification requirements regarding NOA.	**Grievance, Appeal, and Fair Hearing Information** ▪ NOA — monitored to ensure member rights and responsibilities compliance. ▪ 55 percent of prior authorization files demonstrated that notification of rights and responsibilities was not adequate. ▪ **Must monitor prior authorization and case management staff to ensure that member rights and responsibility notification requirements are met.**	**Grievance, Appeal, and Fair Hearing Information** ▪ Members are notified in a timely manner of their rights and responsibilities when there is a denial of service.	**Grievance, Appeal, and Fair Hearing Information** ▪ Members are notified in a timely manner of their rights and responsibilities when there is a denial of service.	**Grievance, Appeal, and Fair Hearing Information** ▪ Members are notified in a timely manner of their rights and responsibilities when there is a denial of service.	**Grievance, Appeal, and Fair Hearing Information** ▪ Members are notified in a timely manner of their rights and responsibilities when there is a denial of service.
QAPI						
Access Standards	**Availability of Services/Timely Access to Services** ▪ HCBS — no waiting list for services. ▪ HCBS — transportation times were monitored. ▪ BH — did monitor and evaluate accessibility of services, amount,	**Availability of Services/Timely Access to Services** ▪ HCBS — no waiting list for services. ▪ HCBS — transportation times were monitored. ▪ BH — did monitor and evaluate accessibility of services, amount,	**Availability of Services/Timely Access to Services** ▪ HCBS — no waiting list for services. ▪ HCBS — transportation times were monitored; transportation issues were primary reason for member complaints.	**Availability of Services/Timely Access to Services** ▪ HCBS — did have waiting list for services. ▪ HCBS — transportation times were monitored; less than 1 percent of members who utilized services reported an issue.	**Availability of Services/Timely Access to Services** ▪ HCBS — no waiting list for services. ▪ HCBS — transportation times were monitored. ▪ Office wait times were no longer than 45 minutes; action has	**Availability of Services/Timely Access to Services** ▪ HCBS — no waiting list for services. ▪ HCBS — transportation times were monitored. ▪ Office wait times were no longer than 45

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	and type of services. ▪ BH — did develop or modify provider network once need identified; had added a psychiatrist, Level II Group Home in Sierra Vista and counselors. ▪ Office wait times were no longer than 45 minutes; action has been taken. ▪ PCP appointments available within 21 days; specialty physician available within 30 days of referral. ▪ BH — emergency appointments within 24 hours of referral. ▪ BH — routine appointments within 30 days of referral. ▪ BH — did have mechanism to ensure referrals made when need identified.	and type of services. ▪ BH — did not resolve appointment wait list in a timely manner. ▪ **BH — must ensure that provider network is expanded or modified in a timely manner once a need for services has been identified.** ▪ HCBS — had mechanisms to monitor sufficient provision of authorized services and took action, as appropriate. ▪ Office wait times were no longer than 45 minutes; no action has needed to be taken. ▪ PCP appointments available within 21 days; specialty physician available within 30 days of referral. ▪ BH — did not monitor emergency or routine appointment times. ▪ **BH — must monitor and evaluate its compliance with emergency and routine appointment times.**	▪ BH — did monitor and evaluate accessibility of services, amount and type of services; if wait time exceeds 7 days, the network was evaluated for sufficiency. ▪ Office wait times were no longer than 45 minutes; action has been taken. ▪ PCP appointments available within 3 to 6 days; specialty physician available within 4 to 14 days of referral. ▪ BH — emergency appointments within 24 hours of referral. ▪ BH — routine appointments within 30 days of referral.	▪ Office wait times were no longer than 45 minutes; action has been taken — CAP required if times are longer. ▪ BH — did monitor and evaluate accessibility of services, amount, and type of services. ▪ Did develop or modify provider network once need identified; added an assisted living provider in Maricopa County. ▪ PCP appointments available within 21 days; specialty physician available within 30 days of referral. ▪ BH — emergency appointments within 24 hours of referral. ▪ BH — routine appointments within 30 days of referral.	been taken; Contract representative visits providers who do not meet standard. ▪ BH — did monitor and evaluate accessibility of services, amount, and type of services. ▪ PCP appointments available within 21 days; specialty physician available within 30 days of referral. ▪ BH — emergency appointments within 24 hours of referral. ▪ BH — routine appointments within 30 days of referral.	minutes. ▪ BH — did monitor and evaluate accessibility of services, amount, and type of services. ▪ PCP appointments available within 21 days; specialty physician available within 30 days of referral. ▪ BH — emergency appointments within 24 hours of referral. ▪ BH — routine appointments within 30 days of referral.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
		▪ Home modifications not approved within 90 days of need identification.				
	Delivery Network ▪ Network Development and Management Plan and Evaluation was approved. ▪ BH — did develop or modify provider network once need identified. ▪ BH — Conducted BH Satisfaction Survey/ Needs Assessment of Providers. ▪ BH — had a limited number of providers serving rural communities secondary to availability. ▪ Monitoring of coordination of services between BH and other involved agencies/parties needs to be done.	**Delivery Network** ▪ Network Development and Management Plan and Evaluation was approved. ▪ No contracted OT or PT professional in one county. ▪ Conducted Provider Satisfaction Survey; made changes based on monitoring. ▪ BH — had a wait list for services, but has been corrected. ▪ BH — did not develop and/or modify provider network once need identified. ▪ **BH-— must ensure that the network is expanded or modified to allow members to receive services timely.**	**Delivery Network** ▪ Network Development and Management Plan and Evaluation was approved. BH — did develop or modify provider network once need identified	**Delivery Network** ▪ Network Development and Management Plan and Evaluation was approved.	**Delivery Network** ▪ Network Development and Management Plan and Evaluation was approved.	**Delivery Network** Network Development and Management Plan and Evaluation was approved
	Cultural Competency of Services ▪ Cultural Competency Plan met requirements.	**Cultural Competency of Services** ▪ Cultural Competency Plan met requirements.	**Cultural Competency of Services** ▪ Cultural Competency Plan met requirements.	**Cultural Competency of Services** ▪ Cultural Competency Plan met requirements.	**Cultural Competency of Services** ▪ Cultural Competency Plan met requirements.	**Cultural Competency of Services** ▪ Cultural Competency Plan met requirements.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	▪ Conducted an evaluation of its plan. ▪ Took action when evaluation showed trend/need. ▪ Had orientation and on-going education program for providers and employees about providing culturally-competent services. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Member Handbook contained information on cultural competency. ▪ Provider Newsletter provided on-going information related to cultural competency.	▪ Conducted an evaluation of its plan. ▪ Took action when evaluation showed trend/need. ▪ Had orientation and on-going education program for providers and employees to assist them in providing culturally-competent services. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Member Handbook contained information on cultural competency. ▪ Provider Newsletter provided on-going information related to cultural competency. ▪ Member Provider Council did not represent a cross section of the population and community.	▪ Conducted an evaluation of its Plan. ▪ Took action when evaluation showed trend/need. ▪ Received 3 complaints regarding cultural competency from ALTCS members. ▪ Had orientation and on-going education program for providers and employees about providing culturally-competent services. ▪ Provider Newsletter provided on-going information related to cultural competency. ▪ Separate mailing on providing culturally-competent services sent out to providers. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Members have not been provided	▪ Conducted an evaluation of its plan. ▪ Took action when evaluation showed trend/need. ▪ Had orientation and on-going education program for providers and employees about providing culturally-competent services. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Member Handbook contained information on cultural competency. ▪ Member Newsletter provided on-going information related to cultural competency.	▪ Conducted an evaluation of its plan. ▪ Took action when evaluation showed trend/need. ▪ Had orientation and on-going education program for providers and employees about providing culturally-competent services. ▪ Provider Manual contains information on providing services in culturally-competent manner. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Member Handbook contained information on cultural competency. ▪ Member Newsletter provided on-going information related to cultural competency.	▪ Conducted an evaluation of its Plan. ▪ Took action when evaluation showed trend/need. ▪ Had orientation and on-going education program for providers and employees about providing culturally-competent services. ▪ Provider Manual contains information on providing services in culturally-competent manner. ▪ Provider Newsletter provided on-going information related to cultural competency. ▪ Enrollment materials provided evidence that members received instruction about obtaining culturally-competent materials as well as translation and interpretive services. ▪ Member Handbook contained information on cultural competency.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
			on-going information about the availability of culturally-competent services. ▪ **Must take steps to provide members with on-going cultural competency information.**			
Coordination and Continuity of Care	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ Did ensure that members are informed of specific health care needs requiring follow- up care. ▪ No issues related to coordination and discharge planning of members in the monthly transitional program. ▪ Case managers did assess members for the most integrated/least restricted setting. ▪ System in place to ensure timely coordination related to transition among contracted agencies	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ Did ensure that members are informed of specific health care needs requiring follow- up care. ▪ System in place to ensure timely coordination related to transition among contracted agencies and program Contractors. ▪ System in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities. ▪ Case managers did assess members for the most	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ System in place to ensure timely coordination related to transition among contracted agencies and program Contractors. ▪ System in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities. ▪ Case managers did assess members for the most integrated/least restricted setting. ▪ BH — did monitor to ensure services are provided in	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ Did ensure that members are informed of specific health care needs requiring follow- up care. ▪ BH — did monitor to ensure services are provided in coordination with PCP. ▪ BH — did not monitor to ensure services are provided in coordination with other involved agencies and parties. ▪ **BH — must develop a mechanism to ensure services are coordinated with other involved**	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ Did ensure that members are informed of specific health care needs requiring follow- up care. ▪ BH — did monitor to ensure services are provided in coordination with PCP and other involved agencies and parties. ▪ BH — did monitor to ensure that member and/or family involved in needs identification and decision making. ▪ System in place to ensure timely coordination related to transition among contracted agencies	**Care Coordination** ▪ Did ensure a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs. ▪ Did ensure that members are informed of specific health care needs requiring follow- up care. ▪ BH — did monitor to ensure services are provided in coordination with PCP and other involved agencies and parties. ▪ BH — did monitor to ensure that member and/or family involved in needs identification and decision making. ▪ System in place to ensure timely coordination related to transition among contracted agencies

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	and program Contractors. ▪ BH — did monitor to ensure that services are provided in coordination with PCP. ▪ BH — did not monitor to ensure services are provided in coordination with other involved agencies and parties. ▪ **Must monitor to ensure that care is provided in coordination with other involved agencies and parties.** ▪ BH — did monitor to ensure that member and/or family involved in needs identification and decision making. ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — did ensure members receive uninterrupted services and supports. ▪ HCBS — did monitor non-provision of authorized services. ▪ HCBS — action taken in response to the	integrated/least restricted setting. ▪ BH — deficient in coordination of care with PCP, other involved agencies and parties. ▪ **BH — must monitor to ensure BH services provided in coordination with PCP and other involved agencies and parties.** ▪ BH — did not monitor to ensure that the member and/or family were involved in needs identification and decision making. ▪ **BH — must implement monitoring activities to ensure members and families are involved in treatment planning and decision-making.** ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — transitioning of BH members to ALTCS was appropriate and services were not	coordination with PCP and other involved agencies and parties. ▪ BH — did monitor to ensure that member and/or family involved in needs identification and decision making. ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — did ensure members receive uninterrupted services and supports. ▪ HCBS — did monitor non-provision of authorized services. ▪ HCBS — action taken in response to the results of monitoring for non- provision of services.	**agencies and parties.** ▪ System in place to ensure timely coordination related to transition among contracted agencies and program Contractors. ▪ System in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities. ▪ Case managers did assess members for the most integrated/least restricted setting. ▪ BH — did monitor to ensure that member and/or family involved in needs identification and decision making. ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — did ensure members receive uninterrupted services and supports. ▪ HCBS — did monitor non-provision of authorized services.	and program Contractors. ▪ System was not in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities. ▪ **Should develop and implement a system to label individual case files for transitional members to facilitate recognition of the special program requirements.** ▪ Case managers did assess members for the most integrated/least restricted setting. ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — did ensure members receive uninterrupted services and supports. ▪ HCBS — did monitor non-provision of authorized services.	and program Contractors. ▪ System was not in place to ensure timely and appropriate planning for Transitional Program members in nursing. ▪ **Should revise their policy to include actions for tracking and processing Transitional Program Members who are admitted to a nursing facility.** ▪ Case managers did assess members for the most integrated/least restricted setting. ▪ BH — did coordinate with RBHA to ensure members appropriately transitioned. ▪ BH — did ensure members receive uninterrupted services and supports. ▪ HCBS — did monitor non-provision of authorized services.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	results of monitoring for non- provision of services. **Special Needs Requirements** ▪ BH — did screen to identify needs for EPSDT members; 3 cases identified as needing services. ▪ BH — took about 3 months to get approval or refusal of parent/ guardian for BH services for 2 cases; no care affected as parents refused referral. ▪ **BH—-encouraged to re-evaluate current processes to ensure members referred according to appointment standards.**	interrupted. ▪ HCBS — did monitor non-provision of authorized services. ▪ HCBS — action taken in response to the results of monitoring for non- provision of services. ▪ Assessments timely for identifying most integrated, least restrictive setting for members. **Special Needs Requirements** ▪ Used standardized assessment tool for initial face-to-face visit. ▪ BH — did screen to identify needs for EPSDT members. ▪ BH — did have a mechanism in place to ensure referral was made when need identified. ▪ BH — did have mechanism to monitor whether EPSDT members referred to BH received services.	**Special Needs Requirements** ▪ BH — did screen to identify needs for EPSDT members; all members identified were receiving services already. ▪ BH — did have a mechanism in place to ensure referral was made when need identified. ▪ BH — did have mechanism to monitor whether EPSDT members referred to BH received services.	**Special Needs Requirements** ▪ BH — did screen to identify needs for EPSDT members. ▪ BH — did have a mechanism in place to ensure referral was made when need identified. ▪ BH — did have mechanism to monitor whether EPSDT members referred to BH received services.	**Special Needs Requirements** ▪ BH — did screen to identify needs for EPSDT members. ▪ BH — did have a mechanism in place to ensure referral was made when need identified. ▪ BH — did have mechanism to monitor whether EPSDT members referred to BH received services.	**Special Needs Requirements** ▪ BH — did screen to identify needs for EPSDT members. ▪ BH — did have a mechanism in place to ensure referral was made when need identified. ▪ BH — did have mechanism to monitor whether EPSDT members referred to BH received services.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	▪ BH — did have a mechanism in place to ensure referral was made when need identified.					
Privacy Protection	CY 2005	CY 2005	CY 2005	CY 2005	CY 2005	CY 2005
Coverage and Authorization of Services	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified. ▪ HCBS — action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ No inter-rater reliability	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified. ▪ HCBS — action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ Did have written	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified. ▪ HCBS — action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ Did have written	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified ▪ HCBS – Action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ Did have written	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified. ▪ HCBS — action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ Did have written	**Authorization of Services** ▪ Did have written policies and procedures for monitoring and evaluating utilization of services. ▪ HCBS — did monitor under-utilization. ▪ HCBS — action taken when potential under-utilization issues identified. ▪ HCBS — action taken when potential over-utilization related to emergency department are identified. ▪ Does utilize standardized criteria when making prior authorization decisions. ▪ Did have written

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	policy. ▪ **Policy to outline mechanisms used to apply criteria and monitor consistency with concurrent review decision making needs written.** ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions were made. ▪ Action taken when criteria was not applied in a consistent manner. ▪ Medical Director reviews and signs all denials. ▪ AC — conducted prior authorization and concurrent review monitoring. ▪ Did monitor prior authorization and concurrent review decisions. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Prior authorization decisions made in	policies regarding prior authorization inter-rater reliability. ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions were made. ▪ Action taken when criteria was not applied in a consistent manner. ▪ Medical Director reviews and signs all denials. ▪ AC — conducted prior authorization and concurrent review monitoring. ▪ Did monitor prior authorization and concurrent review decisions. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Prior authorization decisions made in timely manner. ▪ Actions taken when timeframes were not met. ▪ Did monitor pharmacy	policies regarding prior authorization inter-rater reliability. ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions were made. ▪ Action was not taken when criteria were not being applied in a consistent manner by prior authorization staff. ▪ **Consider retesting when inter-rater reliability scores are below targeted goals of 80 percent.** ▪ Medical Director reviews and signs all denials. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Action was not taken when timeframe for making the initial decision was not met. ▪ **Consider including in policy the action taken when timeframes for making initial prior**	policies regarding prior authorization inter-rater reliability. ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions. ▪ Action was not taken when criteria were not being applied in a consistent manner by prior authorization staff. ▪ Medical Director reviews and signs all denials. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Prior authorization decisions made in timely manner. ▪ Actions taken when timeframes were not met. ▪ Did monitor pharmacy utilization data and had processes and timelines in place for review of non-formulary medications.	policies regarding prior authorization inter-rater reliability. ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions were made. ▪ Action taken when criteria was not applied in a consistent manner. ▪ Medical Director reviews and signs all denials. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Prior authorization decisions made in timely manner. ▪ Actions taken when timeframes were not met. ▪ Did monitor pharmacy utilization data and had processes and timelines in place for review of non-formulary medications. ▪ AC — did have standardized criteria for length of stay	policies regarding prior authorization inter-rater reliability. ▪ Monitoring processes were in place to evaluate consistency with which prior authorization decisions were made. ▪ Action taken when criteria was not applied in a consistent manner. ▪ Medical Director reviews and signs all denials. ▪ Did have appropriate timelines for making initial prior authorization decisions. ▪ Prior authorization decisions made in timely manner. ▪ Actions taken when timeframes were not met. ▪ Did monitor pharmacy utilization data and had processes and timelines in place for review of non-formulary medications. ▪ AC — did have standardized criteria for length of stay

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	timely manner. ▪ Actions taken when timeframes were not met. ▪ Did monitor pharmacy utilization data and had processes and timelines in place for review of non-formulary medications. ▪ BH — services authorized were medically-necessary. ▪ AC — assessments for medical necessity related to level of care of institutionalized members were conducted. ▪ AC — did have standardized criteria for length of stay determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action taken when criteria not being applied in consistent manner.	utilization data and had processes and timelines in place for review of non-formulary medications. ▪ Did not document in their policy, process utilized for monitoring, oversight, and evaluation of compliance of pharmacy processes and non-formulary medications. ▪ **Documentation of process for monitoring, oversight and evaluation of compliance with pharmacy processes and non-formulary medications needs done.** ▪ HCBS — discharge potential not being considered. ▪ HCBS — inappropriate or delayed assessment of level of care. ▪ BH — had process for determining medical necessity of services. ▪ HCBS — appropriate utilization of services related to intensity and acuity of service.	**authorization decision not met.** ▪ Did monitor pharmacy utilization data and had processes and timelines in place for review of non-formulary medications. ▪ BH — had process for determining medical necessity of services. ▪ AC — assessments for medical necessity related to level of care of institutionalized members were conducted. ▪ AC — did have standardized criteria for length of stay determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action was not taken when criteria not being applied in consistent manner; scores averaged 69 percent. ▪ **Consider retesting when inter-rater reliability score below targeted level**	▪ AC — did have standardized criteria for length of stay determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action taken when criteria not being applied in consistent manner. ▪ BH — services authorized were medically-necessary.	determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action taken when criteria not being applied in consistent manner. ▪ BH — services authorized were medically-necessary.	determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action taken when criteria not being applied in consistent manner. ▪ BH — services authorized were medically-necessary.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
		▪ AC — did have standardized criteria for length of stay determinations. ▪ AC — processes were in place for inter-rater reliability for concurrent review decisions. ▪ AC — action taken when criteria not being applied in consistent manner. ▪ AC — case managers assessed institutionalized members for possible discharge to lower levels of care.	**of 80 percent.**			
	Emergency and Post-Stabilization Services CY 2005	**Emergency and Post-Stabilization Services** CY 2005	**Emergency and Post-Stabilization Services** CY 2005	**Emergency and Post-Stabilization Services** CY 2005	**Emergency and Post-Stabilization Services** CY 2005	**Emergency and Post-Stabilization Services** CY 2005
Structure and Operation Standards	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing. ▪ Did have a system in place for credentialing and recredentialing providers. ▪ Did recredential providers at least every	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing except for ones addressing temporary and organizational credentialing. ▪ **Must finalize and implement a policy and procedure that**	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing. ▪ Did have a system in place for credentialing and recredentialing providers. ▪ Did recredential providers at least every	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing. ▪ Did have a system in place for credentialing and recredentialing providers. ▪ Did recredential providers at least every	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing except for ones addressing temporary and organizational credentialing. ▪ **Must address organizational credentialing in their**	**Provider Selection** ▪ Did have appropriate policies and procedures relating to credentialing and recredentialing. ▪ Did have a system in place for credentialing and recredentialing providers. ▪ Did recredential providers at least every

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	3 years. ▪ Used member complaint information and information from QI activities in recredentialing activities. ▪ Did not validate or re-validate licensing of providers every 3 years. ▪ Did not check to determine if provider was in compliance with any applicable State or Federal requirements. **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005	**includes temporary and organizational credentialing.** ▪ Had an effective provider credentialing and recredentialing process; 100 percent file compliance. ▪ Did recredential providers at least every 3 years. ▪ Used member complaint information and information from QI activities in recredentialing activities. ▪ Did not conduct facility credentialing nor validate licensure; no policy and procedure relating to credentialing of facilities. **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005	3 years. ▪ Used member complaint information and information from QI activities in recredentialing activities. **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005	3 years. ▪ Used member complaint information and information from QI. **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005	**credentialing and recredentialing policy and procedure.** ▪ **Must include date of completion for temporary/ provisional credentialing.** ▪ Did have a system in place for credentialing and recredentialing providers. ▪ Did recredential providers at least every 3 years. ▪ Used member complaint information and information from QI **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005	3 years. ▪ Used member complaint information and information from QI. **Enrollment and Disenrollment** CY 2005 **Subcontractual Relationships and Delegation** CY 2005
Measurement and Improvement	**QI Program** ▪ QM/PI Plan (CYE	**QI Program** ▪ QM/PI Plan (CYE	**QI Program** ▪ QM/PI Plan (CYE	**QI Program** ▪ QM/PI Plan (CYE	**QI Program** ▪ QM/PI Plan (CYE	**QI Program** ▪ QM/PI Plan (CYE

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
Standards	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Adopted and disseminated practice guidelines to providers. ▪ Guidelines based on national and community standards.	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Adopted and disseminated practice guidelines to providers. ▪ Guidelines based on national and community standards.	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Adopted and disseminated practice guidelines to providers. ▪ Guidelines based on national and community standards.	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Does have established practice guidelines, but not a complete set. ▪ Has not distributed practice guidelines to providers. ▪ **Should continue to develop practice guidelines and ensure distribution to providers.** ▪ Guidelines based on national and community standards.	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Adopted and disseminated practice guidelines to providers. ▪ Guidelines based on national and community standards.	2004) and Annual QM/PI Evaluation (CYE 2003) submitted and approved ▪ Utilization Management Plan (CYE 2004) and UM Evaluation (CYE2003) submitted and approved **Practice Guidelines** ▪ Adopted and disseminated practice guidelines to providers. ▪ Guidelines based on national and community standards.
Health Information Systems Standards	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate	▪ Difference between expected and observed encounter submission reasonable. ▪ Reviewed encounter data validation results and takes measures to improve complete, timely, and accurate

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.	data. ▪ Did submit complete, accurate, and timely encounter data to AHCCCSA. ▪ Had an ESTR to link claim to an adjudicated or pended encounter returned to contractor. ▪ Tracked encounter submission volume to AHCCCSA to identify possible omissions.
Grievance System	**Grievances and Appeals** ▪ Had written policies and procedures that comply with regulations. ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue	**Grievances and Appeals** ▪ Had written policies and procedures that comply with regulations. ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue	**Grievances and Appeals** ▪ Had written policies and procedures that comply with regulations. ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue	**Grievances and Appeals** ▪ Had written policies and procedures that comply with regulations. ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue	**Grievances and Appeals** ▪ Had written policies and procedures that complied with regulations except that their policy did not address Expedited Appeals. ▪ **Should add Expedited Appeals to their existing policy.** ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints	**Grievances and Appeals** ▪ Had written policies and procedures that comply with regulations. ▪ Each grievance and appeal thoroughly investigated and facts gathered from all parties. ▪ Had process for reviewing and evaluating complaints and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or procedure 100 percent of the time. ▪ Decisions stated 15 day appeal rights. ▪ Monitored member and	reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or procedure 90 percent of the time. ▪ Decisions stated 30 day appeal rights. ▪ HCBS — 6 out of 7	reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or procedure 95 percent of the time. ▪ Decisions stated 30 day appeal rights. ▪ 90 percent of files	reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or procedure 80 percent of the time. ▪ **Should include reference to applicable statute, rule, policy, or**	and allegations. ▪ Had developed action plan to reduce/eliminate likelihood of a complaint issue reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or	reoccurring and implemented appropriate interventions. ▪ Did incorporate successful interventions into QM program. ▪ Grievance and Appeal Acknowledgement letter was sent timely. ▪ Issued decisions timely. ▪ Staff not involved in any previous decision reviews the appeals. ▪ Medical reviews conducted by professionals who had appropriate clinical expertise. ▪ Nature/issue of grievance identified and reasons supporting decisions was given 100 percent of the time. ▪ Decisions included reference to applicable statute, rule, or procedure 95 percent of the time. ▪ Decisions stated 30 day appeal rights. ▪ 100 percent of files

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	provider complaints. ▪ HCBS — 100 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ HCBS — 100 percent of NOAs gave specific reason for intended action. ▪ HCBS — 86 percent of NOAs used language commonly understood and appropriate for the layperson; information on one form was written in Spanish with appeal rights in English. ▪ **HCBS — needs to ensure that NOA forms are written on the appropriate form to ensure members understand their appeal rights.** ▪ AC — NOA used language commonly understood by layperson. ▪ AC — calculation of dates for filing grievances and appeals was correct.	NOAs contained all required components in language commonly understood and specific to member. ▪ HCBS — 60 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ **HCBS — must notify members in a timely manner of the rights and responsibilities.** ▪ NOAs were not sent to DHCM as required. ▪ AC — 60 percent of files demonstrated that reason for intended action was not specific to member nor at appropriate level of understanding. ▪ **AC — NOA must give specific reason for intended action and be in a common language for laypersons.** ▪ HCBS — 65 percent of NOAs gave specific reason for intended action. ▪ HCBS — 55 percent of	reviewed, members sent NOA no later than 3 business days from denial date. ▪ HCBS — 90 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ HCBS — 95 percent of NOAs gave specific reason for intended action. ▪ HCBS — 95 percent of NOAs used language commonly understood and appropriate for the layperson. ▪ HCBS — 75 percent of files reviewed, grievance and appeal dates calculated correctly. ▪ **HCBS — should review grievance and appeal dates to ensure correct calculation.** ▪ AC — 95 percent of NOAs gave specific reason for intended action. ▪ AC —100 percent of NOA. used language	**contract clause when denying claim dispute.** ▪ Decisions stated 30 day appeal rights. ▪ 95 percent of files reviewed, members sent NOA no later than 3 business days from denial date. ▪ HCBS — 100 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ AC — 95 percent of NOAs gave specific reason for intended action. ▪ HCBS — 90 percent of NOAs gave specific reason for intended action. ▪ AC — 95 percent of NOAs used language commonly understood and appropriate for the layperson. ▪ HCBS — 90 percent of NOA used language commonly understood and appropriate for the layperson.	procedure 80 percent of the time. ▪ **Include applicable statue, rule, and procedure in all decisions.** ▪ Decisions stated 15 day appeal rights. ▪ 100 percent of files reviewed, members sent NOA no later than 3 business days from denial date. ▪ HCBS — 85 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ AC — 95 percent of NOAs gave specific reason for intended action. ▪ HCBS — 90 percent of NOAs gave specific reason for intended action. ▪ AC — 90 percent of NOA used language commonly understood and appropriate for the layperson. ▪ HCBS — 100 percent	reviewed, members sent NOA no later than 3 business days from denial date. ▪ HCBS — 100 percent of files reviewed, members were provided an NOA at least 10 days prior to date service was to be reduced, suspended, or terminated. ▪ AC — 100 percent of NOAs gave specific reason for intended action. ▪ HCBS — 80 percent of NOAs gave specific reason for intended action. ▪ AC — 95 percent of NOAs used language commonly understood and appropriate for the layperson. ▪ HCBS — 90 percent of NOA used language commonly understood and appropriate for the layperson. ▪ AC — 95 percent of files reviewed, grievance and appeals dates calculated correctly. ▪ HCBS — 85 percent of files reviewed,

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
	▪ HCBS — calculation of dates for grievance and appeals was not always correct. ▪ **HCBS — must ensure deadlines are calculated correctly; schedule of dates to assist in calculating grievances and appeals timelines was given to the Contractor.**	NOAs used language that was commonly understood appropriate to a layperson. ▪ **HCBS — NOA must give reason for intended action in a common language for laypersons.** ▪ AC – 85 percent of records indicated calculation of dates for filing grievances and appeals was correct. ▪ HCBS — 55 percent of records indicated calculation of dates for filing grievances and appeals was correct. ▪ **HCBS — deadlines for filing appeals must be calculated correctly.** ▪ Inter-rater reliability was conducted. ▪ Providers informed of grievance and appeals processes. ▪ Adequate investigation process; incorporated findings into QI processes. ▪ G and appeals decisions were consistent, reliable,	commonly understood and appropriate for the layperson. ▪ AC — 90 percent of files reviewed, grievance and appeals dates calculated correctly.	▪ AC — 95 percent of files reviewed, grievance and appeals dates calculated correctly. ▪ HCBS — 90 percent of files reviewed, grievance and appeals dates calculated correctly.	of NOA used language commonly understood and appropriate for the layperson. ▪ AC — 100 percent of files reviewed, grievance and appeals dates calculated correctly. ▪ HCBS — 65 percent of files reviewed, grievance and appeals dates calculated correctly. ▪ **HCBS — must calculate grievance and appeal dates correctly.**	grievance and appeals dates calculated correctly.

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
		and relevant. ▪ Four cases in which acknowledgement of grievances and appeals were not timely or reasons for action did not indicate applicable statute, procedure, or rule. ▪ **Must acknowledge receipt of grievances and appeals in timely manner.** ▪ Date of denial not provided in documentation so timeliness of member notification of intended action could not be determined. ▪ **NOA must contain effective date of action.**				
	Fair Hearings CY 05	**Fair Hearings** CY 05	**Fair Hearings** CY 05	**Fair Hearings** CY 05	**Fair Hearings** CY 05	**Fair Hearings** CY 05

Summary of Combined Results and Compliance with BBA regulations

Enrollee Rights

Language/Translation Services Requirements

The BBA regulations focus on ensuring that members receive required information in a manner and format that can be easily understood, taking into consideration cultural and linguistic needs and disabilities of members. In addition, written material should be

translated into regularly encountered languages in the Contractors' service areas spoken by a significant number or percentage of the population eligible to be served (5 percent). Oral interpretation is required to be available for any language.

The State placed a great deal of emphasis on meeting language needs of members; important as the State has a significant Hispanic population. The results of the review indicated that there was adequate assessment of languages spoken among all Contractors and all of them translated some or all of their member materials into Spanish, even when the population did not quite meet the 5 percent requirement. One Contractor translated materials into Russian. Three Contractors hired Spanish speaking case managers and one Contractor signed a contract with a Russian interpreter as a result of their assessment findings.

All Contractors had adequate translation services and the ability to track utilization. Additional review will be done in CY 2005 to identify the degree of use of services and if the services are adequately meeting the members' needs. All Contractors, except one, educated providers, employees, and members about the availability of translation services and how to access them.

Information Requirements

The BBA requires that members are informed of their rights, including, but not limited to:

- receive information regarding his or her health care;
- be treated with respect and with due consideration for member dignity and privacy;
- receive information on available treatment options and alternatives;
- participate in decisions regarding his or her health care, including the right to refuse treatment;
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- obtain a second opinion from an appropriately qualified health care professional;
- request and receive a copy of his or her medical records, and to request that they be amended or corrected; and
- free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the member is treated.

In addition, there is general and specific information that is required to be given to members that relate to areas such as:

- the basics of managed care;
- benefits covered;
- cost sharing, if any;

- service area, names, locations, telephone numbers of , and non-language spoken by current contracted providers, and including identification of providers that are not accepting new patients (hospitals, PCP, specialists);
- benefits that are covered under the State plan but are not covered under the contract, including how and where the member may obtain those benefits, any cost sharing, and how transportation is provided;
- any restrictions on the member's freedom of choice among network providers;
- the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled;
- the policies on referrals for specialty care and for other benefits not furnished by the member's primary care provider; and
- physician incentive plans.

There are also information requirements specific to providers to ensure that they abide by and protect the members' rights related to treatment options, second opinion referrals, open discussions, and billing. Each Contractor is also obligated to provide each member with written notice of any change in significant information at least 30 days before the intended effective date of the change. If contracted providers terminate their contracts, the Contractor additionally is obligated to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who receives his or her primary care from, or is seen on a regular basis by, the terminated provider.

AHCCCSA has determined that information requirements, both general and specific, were met primarily through Member Handbook reviews (a copy of the form is provided in Appendix B). The review also documented that each Contractor had a Provider Manual. It also was indicated that one Contractor did not adequately inform members using HCBS of their discharge potential and did not have care options discussed with them.

Emergency Services/Post-Stabilization Services Information

These regulations require Contractors to inform beneficiaries of their right to obtain emergency care and services without prior authorization and the right to post-stabilization services following an emergency medical condition. They also require the Contractor to inform the members of the locations of the emergency facilities and of the member's right to receive these services without prior authorization.

Regulations Regarding Member Rights for Review in CYE 2005
Emergency/Post-Stabilization standards will be evaluated during CYE 2005.

Advance Directives

The BBA requires each Contractor to maintain written policies and procedures concerning Advance Directives with respect to all adult individuals receiving medical care through the health plan. Further, all adult members must be given written information concerning their rights under State law to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. The Contractor is obligated to provide the information to the member at the time of initial enrollment, or if the member is incapacitated at time of enrollment, follow-up procedures must be in place to ensure that the information is given to the individual directly as soon as is appropriate. If the member is incapacitated at time of enrollment, the Contractor may give Advance Directive information to the member's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of an incapacitated member. Additionally, the Contractor needs to ensure that documentation is contained in the medical record as to whether or not the individual has executed an Advance Directive. The provision of care to a member cannot be conditioned or otherwise discriminated against based on whether or not the individual has executed an Advance Directive. The Contractor must inform individuals that complaints concerning non-compliance with the Advance Directive may be filed with the State survey and certification agency.

Advance Directive information supplied by the Contractor must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law. Additionally, if a Contractor has any statement of limitation advising that they cannot implement an Advance Directive as a matter of conscience. At a minimum, this statement should:

- clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians,
- identify the state legal authority permitting such objection, and
- describe the range of medical conditions or procedures affected by the conscience objection.

Advance Directives will be reviewed by AHCCCSA during CY 2005.

Grievance, Appeals, and Fair Hearing Information Requirements

Under the BBA, Contractors are obligated to inform members of their rights related to grievances, appeals, and fair hearings. Specifically, this includes:

- their right to file grievances and appeals;
- the method for obtaining a hearing;
- the rules that govern the grievance, appeals, and fair hearing processes;

- their rights to representation at the hearing;
- the requirements and timeframes for filing a grievance or appeal;
- the availability of assistance in the filing process;
- the toll-free numbers that the member can use to file a grievance or an appeal by phone; and
- the fact that, when requested by the member:
  - benefits will continue if the member files an appeal or a request for State fair hearing within the time frames specified for filing, and
  - the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

The review findings determined that the member rights and responsibilities related to grievance, appeals, and fair hearing information was supplied to members in NOAs. Only one Contractor had deficiencies and they were required to implement a CAP.

Regulations Regarding Member Rights for Review in CYE 2005
These elements will be reviewed for compliance during CYE 2005: ▪ give each member written notice of any change that the State defines as "significant" at least 30 days before the intended effective date of the change; and ▪ provide information to members that they have a right to receive a copy of his or her medical records, and request that they be amended or corrected (reviewed with two Contractors only).

QAPI

Access Standards

Availability of Services, Accessibility, and Delivery Network

These regulations require Contractors to have mechanisms to monitor their provider networks on a regular basis to ensure adequate access to all medically-necessary services based on:

- the anticipated Medicaid enrollment;
- the expected utilization of services, considering Medicaid member characteristics and health care needs;
- the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services;
- the number of network providers who are not accepting new Medicaid patients; and

- the geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

Additionally, the standards have requirements related to:

- direct access to a women's health specialist to provide women's routine and preventive health care services;
- provision of a second opinion, if requested, either within or outside of the network at no cost to the member;
- services and payment for these services may be provided outside of the network if the managed care organization (MCO) is unable to provide them within the network; and
- physician incentive programs.

The EQR identified that each Contractor was required to file a Network Development and Management Plan as well as an annual evaluation of the plan. There was evidence of approval of the plans by AHCCCSA. Two Contractors modified their networks in relation to their monitoring. One Contractor added a psychiatrist, a Level II Group Home in Sierra Vista, and some counselors to their BH Network. The other Contractor added an assisted living facility.

Significant attention in the AHCCCSA review was given to monitoring availability and timeliness of routine and specialty services for ALTCS members by each Contractor. All Contractors, but one, did not have an existing wait list for HCBS. Only one Contractor was specifically identified as not monitoring routine or emergency appointment times related to BH. This Contractor also was not timely in resolving an appointment wait list for BH services. Primary care and specialty physician appointment and office wait times were in compliance with required standards by all Contractors. One Contractor was delayed in providing home modifications within State timeliness standards.

Cultural Competency

The BBA requires Contractor's to participate in the State's efforts to promote the delivery of services in a culturally-competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The review identified that each Contractor filed a Cultural Competency Plan with AHCCCSA which met State requirements and that they conducted an annual evaluation of the plan. All Contractors took action when the evaluation identified a need. All Contractors had an orientation and on-going education program for employees and providers about providing culturally-competent services. One Contractor had identified that three complaints regarding cultural competency were filed during 2004. Members were provided information on how to access culturally-related materials and translation services through orientation programs, enrollment materials,

and newsletters. Only one Contractor did not have a program in place to provide ongoing information about culturally-competent services to its members.

To promote a collaborative effort to enhance the service delivery system in the community, each Contractor was required to have a Member/Provider Council that was to include a cross representation of both members/families/significant others, advocacy groups, and providers that reflect the population and community served.

Regulations Regarding Access Standards for Review in CYE 2005
The following elements will be reviewed for compliance during CYE 2005: ▪ provide female members with direct access to a women' health specialist within the network for covered care necessary to provide women's routine and preventive health care services; ▪ provide for a second opinion from a qualified health care professional within the network or arranges for the member to obtain one outside the network at no cost to the member; and ▪ if the network is unable to provide necessary services, covered under the contract, to a particular member, the Contractor must adequately and timely cover these services out of network.

Coordination and Continuity of Care

Primary Care Coordination

In summary, these BBA regulations relate to:

- assurance that each member has a PCP;
- assessment, treatment plan, and care coordination of all members is being done by PCPs with member participation, and in consultation with any specialists caring for the member;
- coordination of services furnished by the Contractors with services the member receives from any other health plan;
- ensure that a member with special health care needs has direct access to specialists as appropriate for the member's condition and identified needs; and
- in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements.

The review identified that all Contractors made 'best effort' attempts toward conducting initial assessments of the health care needs of members. Efforts were also directed toward assuring that members were in the most integrated/least restrictive setting. All Contractors were identified as ensuring members received uninterrupted services and supports in the BH arena. Coordination with the appropriate

RBHA was done by all Contractors to ensure coordination of services between the physical and behavioral areas of health care. In the area of HCBS, non-provision of authorized services monitoring was done to identify service access issues. The areas of greatest deficiencies demonstrated were:

- three Contractors had difficulties coordinating care among PCPs and other involved agencies and parties, and
- two Contractors did not have systems in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities.

Special Needs Requirements

These BBA requirements ensure that Contractor's implement mechanisms to assess each Medicaid member identified as having special health care needs to identify any on-going special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. PCPs serving members with special health care needs must be made aware of and are involved in procedures for:

- assessing individuals with special health care needs,
- treatment planning, and
- coordinating the care of individuals with special health care needs with the care provided by other health plans to prevent duplication of those activities.

Finally, a mechanism is in place to ensure that members with special health care needs (which essentially is all ALTCS members) have direct access to specialists, as appropriate, for the health condition and identified needs. This can be through a process such as a standing referral or an approved number of visits.

The review identified that every ALTCS member is assigned a PCP along with a Case Manager and that Case Managers conduct a comprehensive assessment of every ALTCS member within 12 business days of enrollment. The review also identified findings for members with potential or actual BH needs. Each Contractor did have a mechanism in place to screen EPSDT members for behavioral health issues and all, but one, were able to ensure timely referrals.

Privacy Protection

In the process of coordinating care, each member's privacy must be protected in accordance with Federal privacy requirements. All medical records and any other health and enrollment information that identifies a particular member must be confidential according to requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Regulations Regarding Coordination and Continuity of Care_Standards for Review in CYE 2005
The following elements will be reviewed for compliance during CYE 2005: ▪ ensure that each member has an on-going source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member; ▪ ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable; and ▪ for members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits), as appropriate, for the member's condition and identified needs.

Coverage and Authorization of Services

Authorization of Services

Contractors are required under the BBA to have written polices related to medical necessity coverage and authorization processes including:

- mechanisms in effect to ensure consistent application of criteria used in making service authorization decisions and that services are not arbitrarily denied or reduced solely because of the illness or condition;
- consultation with requesting providers, when appropriate, for responding to service authorization requests;
- a mechanism to assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease; and
- if decisions to deny a service or authorization request or to authorize the request in an amount, duration, or scope that is less than what was requested, a written notice is provided to member and either written or oral notice is given to provider.

The regulations also address decision and notification timelines, content of service denial notification, and incentive compensation issues related to employees and other professions performing service authorization decisions.

The review demonstrated that all Contractors had written policies and procedures for monitoring and evaluating utilization of services. Standardized criteria were used for decision-making and all but one Contractor had inter-rater reliability policies. Two Contractors were identified as not taking action when criteria were not being applied consistently. Medical Directors review and sign all denials. Concurrent review was done to assess for medical necessity and for appropriateness of level of care. For HCBS, under-utilization of services such as pharmacy and over-utilization of emergency services was monitored with action being taken when issues were identified.

Emergency and Post-Stabilization Services

Contractors are required to pay for emergency care and services regardless of whether the entity that furnishes the services has a contract and they are not allowed to deny payment for treatment obtained under the following circumstances:

- a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes of serious jeopardy, impairment, or dysfunction; and/or
- Contractor representative instructs the member to seek emergency services.

Contractors may not limit what constitutes an emergency medical condition through lists of symptoms or final diagnoses/conditions. The BBA regulations also address issues such as what practitioner is appropriate to determine transfers, limitations on payment denial timelines, prohibition of the use of codes for denying claims, patient non-liability for emergency treatment, and it defines and outlines issues related to post-stabilization services.

These standards were not evaluated during CYE 2004 and will be reviewed during CYE 2005.

Regulations Regarding Authorization of Services Standards for Review in CYE 2005
The following elements will be reviewed for compliance during CYE 2005: ▪ contracting and operational issues relating to required consultation with the requesting provider; ▪ decisions to deny service authorization requests or to authorize a service in an amount, duration, or scope that is less than requested, being made by health care professionals who had appropriate clinical expertise in treating the member's condition or disease; ▪ providers being notified of all adverse action decisions; and ▪ compensation structures/incentives for individuals making service denial decisions.

Structure and Operation Standards

Provider Selection

Structure and Operation Standards for credentialing and recredentialing address policies and procedures and the documentation process for the selection and retention of providers. These include:

- regulations regarding what the policy implications are if any credentialing or recredentialing is delegated;
- provision for non-discrimination against providers, with respect to participation, reimbursement, or indemnification, solely on the basis of their licensure or certification;
- giving the affected providers written notice of the reason for its decision, if the Contractor declines an individual or groups of providers in its network; and
- ensuring that the Contractor does not employ or contract with providers who are excluded from participation in Federal health care programs.

The AHCCCSA review determined that all Contractors had appropriate policies and procedures for credentialing and recredentialing related to individual providers. However, two Contractors did not have these provisions for temporary situations or for facility credentialing and recredentialing processes. Two Contractors also did not validate licensing of providers every three years. Five Contractors did check to determine if the providers were in compliance with Federal and State requirements. All the Contractors used member complaint information and QI information for consideration in recredentialing decisions. The Contractors do check to ensure that employees are not excluded from participation in Federal health care programs.

Enrollment and Disenrollment

These regulations were not reviewed, as they are not applicable to the Contractors. ALTCS is a mandatory program and only the State has the authority to disenroll members.

Subcontractual Relationships and Delegation

These regulations require that prior to any delegation of tasks each Contractor must evaluate the prospective subcontractor's ability to perform the potential delegation activities. Contractual obligations are outlined in the statutes. In addition, the Contractor must monitor the actual performance of the delegated entity through a formal review on an annual basis. If any deficiencies are identified, corrective action must be instituted.

These standards will be reviewed during CYE 2005.

Regulations Regarding Structure and Operations Standards for Review in CYE 2005
The following elements were not reviewed by AHCCCSA during CYE 2004, but will be reviewed for compliance during CYE 2005:
▪ provider selection policies and procedures related to non-discrimination against particular practitioners that serve high-risk populations, or specialize in conditions that require costly treatment;
▪ provisions of non-discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification;
▪ written notification of the reason for its decision if the Contractor declines to include individual or groups of providers in its network;
▪ contracting procedures related to providers excluded from participation in Federal health care programs;
▪ oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor;
▪ before any delegation, the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated;
▪ a written agreement is present that:
– specifies the activities and report responsibilities designated to the subcontractor, and
– provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
▪ monitoring of the subcontractor's performance on an on-going basis and subjecting it to formal review according to a periodic schedule established by the State, consistent with industry standards or State managed care organization (MCO) laws and regulations; and
▪ if any deficiencies or areas for improvement are identified, the Contractor and the subcontractor take corrective action.

Measurement and Improvement Standards

QI/UM Program

The BBA requires that each Contractor have an ongoing quality assessment and performance improvement program for the services it furnishes to its members. The Contractors must have PIPs that focus on clinical and non-clinical areas and that involve the following:

- measurement of performance using objective quality indicators,
- implementation of system interventions to achieve improvement in quality,
- evaluation of the effectiveness of the interventions, and
- planning and initiation of activities for increasing or sustaining improvement.

Each Contractor submitted a Quality Management Performance Improvement (QM/PI) Plan to AHCCCSA for review and approval during CYE 2004. The plans outlined the scope of the program, organizational structure for oversight, and identified staff and

committee roles and responsibilities. They also summarized committee structures, identified membership, and meeting frequency requirements. The plans although in different formats additionally identified to varying degrees information, such as:

- methods for monitoring and evaluating the service delivery system and provider networks,
- descriptions of any delegated activities,
- member rights and responsibilities,
- standards and procedures for privacy regulations,
- description of credentialing and recredentialing processes;
- monitoring processes for ALTCS sites
- grievance system processes,
- performance measures and PIPs,
- planned activities to meet goals of the mandated performance indicators,
- procedures to implement actions to improve care, and
- methods for the dissemination of findings and resulting QM/PI activities to associates and/or network providers.

AHCCCS made recommendations to modify plans if they needed additional information prior to approving them. A discussion of the PMs and the PIPs can be found in Chapters 4 and 5.

Practice Guidelines

Practice guidelines are required and must be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. They should be developed giving consideration to the needs of the ALTCS members and in consultation with contracting health care professionals. They are required to be reviewed, updated periodically as appropriate, and disseminated to all affected providers and upon request, to members and potential members. Decisions for utilization management, care services, member education, coverage of services, and other areas to which the guidelines apply must be consistent with the clinical guidelines.

The AHCCCSA review determined that all Contractors had adopted practice guidelines based on national and community standards. One Contractor did not have a complete set of guidelines and had not disseminated them to providers. The other five did disseminate their complete sets of guidelines to providers.

Regulations Regarding Practice Guideline Standards Not Reviewed in CYE 2004
The regulation concerning application of the guidelines to decision making for UM processes, member education, coverage of services, and other areas to which the guidelines apply were not reviewed by AHCCCSA during CYE 2004. They will be reviewed for compliance during CYE 2005, along with a more extensive review of all the practice guideline regulations.

Health Information Systems

The BBA requires Contractors to maintain an information system that collects, analyzes, integrates, and reports data to achieve the objectives of the health plan. This system must provide information on areas including, but not limited to:

- utilization,
- grievances, and
- disenrollments for other than loss of Medicaid eligibility.

The information system must comply with the following:

- collects data on member and provider characteristics, as specified by the State, and on services furnished to members through an encounter data system or other methods as may be specified by the State; and
- ensure that data received from providers is accurate and complete by:
  - verifying the accuracy and timeliness of reported data,
  - screening the data for completeness, logic, and consistency, and
  - collecting service information in standardized formats to the extent feasible and appropriate.

AHCCCSA conducted a review of encounter data during their CYE 2004 OFR. All six Contractors were determined to have reasonable data rates between expected and observed data submissions. Data validation study results were evaluated and it was determined that the Contractors take measures to improve the submission of complete, timely, and accurate data. Each Contractor had an ESTR to link claims to an adjudicated or pended encounter returned to contractor. Each Contractor tracked encounter submission volume sent to AHCCCSA to identify possible omissions.

Grievance System

The BBA requires each Contractor to have a grievance process, an appeal process, and access to the State's fair hearing system in place for members. A brief summary of regulations covers items such as:

- appropriate definitions of terms related to the grievance system;
- content of the NOA;

- denial decision notification timeframes;
- process for filing oral and/or written appeals with timelines for standard and expedited appeals, including extensions;
- acknowledgement of appeal;
- provision of allowing both member and provider to file appeal on behalf of the member;
- requirement to provide reasonable assistance to member in filing and presenting appeal; and
- opportunity for member to present evidence during phases of grievance system processes.

Additionally, the BBA requires the Contractor to ensure that individuals making the decisions have the appropriate clinical expertise and were not involved in any previous level of review or decision-making. Each Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires and within State-established timeframes. The regulations further address items such as:

- content of notice of appeal resolution;
- availability and participant requirements for State fair hearings;
- grievances and appeals recordkeeping and reporting requirements;
- continuation of benefits circumstances, notification, and duration;
- information required to be given to all providers and subcontractors at the time they enter into a contract; and
- effectuation of reversed appeal resolutions.

Some of the above elements were reviewed in CYE 2004. All BBA regulations regarding Grievance, Appeal, and Fair Hearing standards will be reviewed in CYE 2005. The AHCCCSA review identified that all Contractors had written grievance, appeals, and fair hearing policies and procedures that comply with regulations, with the exception of one Contractor whose policies did not cover expedited appeal situations. Each Contractor had a process for reviewing and evaluating complaints and allegations and thoroughly investigated facts gathered from all parties. Each had developed an action plan to reduce/eliminate the likelihood of a complaint issue reoccurring and implemented appropriate interventions and did incorporate successful interventions into QM program. Evidence was presented that demonstrated that the Contractors both acknowledged receipt of grievances and appeals as well as issued decisions in a timely manner. Professionals who had appropriate clinical expertise and who were not involved in any previous decision reviewed the appeals.

Two contractors had outdated pre-BBA policies which only allowed a 15-day appeal right. Three others allowed a 30-day right to request a state fair hearing, which is in line with BBA regulations. Two Contractors did not reference an applicable statute, rule, or

procedure in the NOA 20 percent of the time, leading to a CAP. One Contractor's NOA letters did not give members the reason for intended action and contained language that may not have been understandable to the layperson. Four Contractors had difficulty calculating correct appeal dates on the HCBS side.

Regulations Regarding Grievance, Appeals, and Fair Hearing Standards Not Reviewed in CYE 2004
The following elements were either not reviewed at some Contractor's sites by AHCCCSA during CYE 2004 and will be reviewed for compliance during CYE 2005, or they need more extensive review during on-site visits in CYE 2005: ▪ ensure that the individuals who make decisions on grievances and appeals are individuals: – who were not involved in any previous level of review or decision-making, and – who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease: ▫ appeal of a denial that is based on lack of medical necessity; ▫ grievance regarding denial of expedited resolution of an appeal; and ▫ grievance or appeal that involves clinical issues; ▪ provide that oral inquiries seeking to appeal an action are treated as appeals and be confirmed in writing, unless the member or provider requests expedited resolution; ▪ provide member reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; ▪ provide member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process; ▪ include, as parties to the appeal: – member and his or her representative, and – legal representative of a deceased member's estate; ▪ Contractor may extend the timeframes by up to 14 calendar days if: – enrollee requests the extension, – Contractor shows that there is a need for additional information and how the delay is in the enrollee's interest.; ▪ if the Contractor extends the timeframes, for any extension not requested by the enrollee, it must give the enrollee written notice of the reason for the delay; ▪ for all appeals, the Contractor must provide written notice of disposition; ▪ for notice of expedited resolution, the Contractor must also make reasonable efforts to provide oral notice; ▪ Contractor must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal; ▪ if the Contractor denies a request for expedited resolution of an appeal, it must: – transfer the appeal to the time frame for standard resolution in accordance with 438.408(b)(2), and – make reasonable effort to give the enrollee prompt oral notice of the denial, and follow up within 2 calendar days with a written notice; ▪ Contractor must provide information about the grievance system processes to all providers and subcontractors at the time they enter into contract; ▪ timely notification of continuation of benefits while the appeal and the State fair hearing are pending and information regarding duration of continued or reinstated benefits; ▪ Contractor must be in compliance with continuation of benefit regulations; ▪ if the final resolution of the appeal is adverse to the enrollee, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section; ▪ if the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires; and ▪ if the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the Contractor or the State must pay for those services, in accordance with State policy and regulations.

Results of EQR Activity Shared with Providers, Members, and Potential Members

According to AHCCCSA, a Newsletter was sent to members in February 2004, which contained information regarding:

- Member/Provider Council findings,
- HCBS Member Satisfaction Survey CYE 2003 results, and
- member diabetes education.

Provision of Input of Members and Other Stakeholders into Quality Strategies of the Organizations

Each ALTCS Contractor has established a Member/Provider Council which participates in providing input on policy and processes for the ALTCS Program. The Council consists of members, family members, advocacy group representatives, providers, and significant others. Minutes and agendas from the Member/Provider Council are sent to AHCCCS by all six Contractors. In addition, each Contractor submits an annual plan outlining the schedule of meetings and the draft goals of the Councils. The AHCCCSA contract also requires an annual member survey to be conducted. Findings of the survey and actions of the Council were not available for inclusion in this final EQR report. All Contractors seem to be experiencing difficulty in varying degrees getting member participation on the Councils. All are exploring avenues to increase the cross representation and/or attendance.

4

Performance Measures Review

Review Methodology

According to the CMS protocol, the following areas are required to be reviewed in relation to performance measurement:

- Assess documentation of processes used to calculate and report performance measures.
  - Do appropriate and complete measurement plans and programming specifications exist that include data tables used and programming logic?
- Review processes used to produce denominators.
  - Are data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) complete and accurate?
  - Is continuous enrollment criteria correctly applied?
  - Are age and gender specifications adhered to?
  - Are clinical codes (e.g., ICD-9, CPT-4, DSM-IV) used appropriately?
  - Are member months or member years calculated correctly?
  - Are correct time parameters used?
  - Were exclusions applied appropriately?
- Review processes used to produce numerators.
  - Are data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO network) complete and accurate?

  - Are clinical codes (e.g., ICD-9, CPT-4, DSM-IV) used appropriately?
  - Are correct time parameters (e.g., admission and discharge dates or treatment start and stop dates) used?
  - Are medical record review documentation and tools adequate?
  - If hybrid method was used, is the integration of administrative and medical record data adequate?
  - If hybrid method or solely medical record review was used, do the results of the medical record review validation substantiate the reported numerator?
- Assess the sampling processes.
  - Is sample unbiased?
  - Does sample treat all measures independently?
  - Are sample size and replacement methodology specifications met?
- Assess submission of required performance measure reports to the State.
  - Are State specifications for reporting performance measures followed?

Additionally, the CMS protocol requires that an overall validation finding be assigned according to the following guidelines:

Fully Compliant	Substantially Compliant	Not Valid	Not Applicable
Measure was fully compliant with State specifications.	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.	Measure deviated from the state specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.	Measure was not reported because Contractor did not have any AHCCCS members that qualified for the denominator.

Performance Measures

Mercer has evaluated the report submitted by AHCCCS in November 2004 which summarized AHCCCS's validation assessment of the MCO's PMs. The AHCCCSA report documented results in each of the areas of the CMS Validation of PM protocol. Mercer did not review any of the Contractor documentation, just the AHCCCS report of results. AHCCCS has reviewed the following measures:

- the percent of diabetic members who had one or more HbA_{1c} tests during the measurement period,

- the percent of diabetic members who had one or more lipid screenings during the measurement period or the preceding year,
- the percent of diabetic members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year, and
- evaluation of ALTCS Contractor compliance with AHCCCS medical policy in initiating HCBS to newly enrolled E/PD members.

Diabetes Care

The purpose of monitoring diabetic care was to increase the numbers of those ALTCS members who receive diagnostic and preventive services. AHCCCSA required several PMs related to diabetes care in addition to testing the number of members who had one or more HbA_{1c} tests, including lipid management and eye care in order to improve the health of ALTCS diabetic members. AHCCCSA performed prior studies and concluded that approximately 20 percent of ALTCS members had diabetes.

HCBS

HCBS services are an integral element of many state Medicaid programs, and their value is that they allow members to live in their own homes or in community-based settings when they otherwise would be at risk for institutionalization. Fifty-eight percent of the ALTCS E/PD population currently reside in home or community-based settings. AHCCCSA wanted to get an indication of the timeliness of certain HCBS waiver services and to evaluate potential obstacles to obtaining services.

Results of PM Review

AHCCCSA had two primary PMs for ALTCS Contractors — diabetes indicators and an HCBS indicator.

Diabetes

AHCCCSA provided a comprehensive report for the diabetes PMs calculated for each of the contactors. Mercer reported on the findings for each of the three diabetic care PMs: HbA1c testing, lipid screening, and eye exams.

The Contractors met HEDIS® 2003 specifications for this measure and AHCCCSA provided the technical appendix with detailed methodologies. AHCCCSA established minimum performance standards (MPS), AHCCCS goals, and long-range benchmark goals for the Contractors and expected the Contractors to meet their MPS and to strive to meet their goals, with the hopes of achieving their benchmarks in the future. The goals and Contractor results are presented on the following page. Also included are the 2002 National Committee on Quality Assurance (NCQA) HEDIS® averages for Medicaid plans.

Measure	MPS	AHCCCSA Goal	Benchmark	2002 Mean
HbA1c testing	51%	55%	85%	74%
Lipid screening	47%	51%	81%	71.7%
Eye exams	31%	35%	64%	47.1%

HbA1c Testing		
Contractor	Percent Receiving Test	Prior Measurement Period Result
Cochise Health	40.9%	42.7%
Evercare Select	56.0%	53.8%
Mercy Care Plan	52.0%	61.1%
Pima Health	54.3%	50.9%
Pinal/Gila County	53.1%	42.1%
Yavapai County	63.9%	66.7%
Overall Results (Based on results from 7 Contractors)	44.6%	47.3%

Lipid Screening		
Contractor	Percent Receiving Test	Prior Measurement Period Result
Cochise Health	52.7%	50.4%
Evercare Select	53.2%	49.1%
Mercy Care Plan	58.2%	54.5%
Pima Health	54.1%	41.0%
Pinal/Gila County	55.4%	51.8%
Yavapai County	59.3%	56.4%
Overall Results (Based on results from 7 Contractors)	51.3%	43.4%

Eye Exams	
Contractor	Percent Receiving Test
Cochise Health	33.6%
Evercare Select	34.4%
Mercy Care Plan	25.9%
Pima Health	32.2%
Pinal/Gila County	43.1%
Yavapai County	44.4%
Overall Results (Based on results from 7 Contractors)	30.0%

The PM report AHCCCSA supplied addresses each of the audit areas CMS requires for assessment. Every audit element was documented sufficiently and all processes were explained adequately. Mercer suggests a rating of "Fully Compliant" be assigned for these measures based on the documentation provided.

HCBS PM Review

AHCCCSA also wrote a comprehensive report for the HCBS PM calculated by each of the plans. This measure is an internal QI project based on contractual requirements. As with the diabetic performance measures, AHCCCSA established an MPS, a goal, and a long-range benchmark standard for the Contractors.

According to the OFRs, some of which were conducted prior to the 2004 results and thus reflective of 2003 results, all Contractors were in full compliance for their performance indicators. The following table depicts AHCCCSA's determination of the various Contractor's compliance with performance measurements.

OFR Determination of Compliance with PMs

BBA Category	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
QM	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.	**Performance Indicators** ▪ Did report their performance using standard performance indicators established or adopted by AHCCCS. ▪ Achieved at least MPS established by AHCCCS. ▪ Showed demonstrable and sustained improvement toward meeting all goals for Indicator QI. ▪ Developed and implemented a CAP to bring the performance up to at least the minimum level established by AHCCCS.

The 2004 performance standards for initiation of HCBS were:

Measure	MPS	Goal	Benchmark
Initiation of HCBS	74%	76%	87%

The Contractor results were:

Contractor	Percent With Service Within 30 Days	Prior Measurement Period Result
Cochise Health	97.7%	98.0%
Evercare Select	68.7%	81.3%
Mercy Care Plan	81.1%	69.7%
Pima Health	97.8%	93.3%
Pinal/Gila County	86.0%	83.0%
Yavapai County	89.7%	85.0%
Overall Results (Based on results from 7 Contractors)	83.7%	83.5%

One Contractors' score showed significant improvement, and another Contractor's rate was significantly below the previous year's result and no longer met the MPS.

The PM report AHCCCSA supplied to Mercer addressed each of the audit areas CMS requires for assessment. Every audit element was documented sufficiently and all processes were explained adequately. Mercer suggests a rating of "Fully Compliant" be assigned for this measure based on the documentation provided.

AHCCCS Plan for Correction

AHCCCSA required CAPs from all Contractors that did not meet the MPS or showed a statistically-significant decline in their rate for any indicator in the most recent measurement period. Contractors that fail to show improvement in the future may be subject sanctions.

AHCCCSA will continue working with Contractors, especially those with the lowest rates, to assist them in reaching goals for these PMs.

5

Performance Improvement Projects Review

Goals and Objectives of PIP Review

Goal

- To assess AHCCCSA's compliance with the CMS protocol for conducting PIPs.

Objectives

- Review the conduct of the Diabetes Management PIPs, including topic selection process, study questions and indicators, identified population and sampling methods, data collection procedures, improvement strategies, process for re-measurement, and findings of re-measurement.
- Summarize the results of the individual ALTCS Contractor PIPs to date.

Methods

Data Collection Tool

AHCCCSA collected data about the individual ALTCS Contractors' PIP activities through a routine reporting requirement established in the Medical Policy Manual, Chapter 980. These Contractor reports, as well as summary findings from AHCCCS to the Contractors, were provided to Mercer for review.

To write this report of AHCCCSA's review of Contractor performance, Mercer used a tool, based on the CMS protocol "Validating PIPs: A protocol for use in Conducting Medicaid EQR Activities," to abstract information from documents provided by AHCCCSA.

Data Sources

AHCCCSA relied on reports from individual Contractors, as well as the results of performance measurement, to assess Contractor performance. The documents reviewed for this report were forwarded to Mercer by AHCCCSA. A listing of documents reviewed is included in Appendix C.

Summary of Findings

Mercer's review of the AHCCCS Diabetes Management PIP covered the following substantive areas/tasks:

1. topic selection process,
2. study questions,
3. study indicators,
4. identified population,
5. sampling methods,
6. data collection procedures,
7. improvement strategies, and
8. re-measurement process and findings.

AHCCCSA prepared detailed specification for all aspects of the project. The individual Contractors collected baseline and remeasurement data in accordance with the specification. The AHCCCSA methods met BBA protocol specifications. They had a clear plan for validating data collection and the results of the validation process were available for review. .

The table below summarizes AHCCCSA findings for the individual Contractors as well as presenting Mercer's summary of the ALTCS Contractor reported improvement activities. The table relates the results of the second round of measurement to the intervention activities selected by each of the Contractors. Generally, the Contractors with multi-pronged intervention strategies showed improvement.

Findings on Re-Measurement and Relation to Intervention Strategies (Task 8)

Contractor	Indicator	Baseline	Re-measure	Improve?	Interventions
Cochise Health	HbA1c Testing	62.3%	80.7%	Yes p=0.01	Patient Interventions *Education*: CHS will notify and encourage home and community-based members to attend any educational sessions available in the area. Provider Interventions *Education*: (1) CHS will notify and encourage home and community-based members to attend any educational sessions available in the area. (2) Area physicians were invited to programs about diabetes presented by Sierra Vista Regional Health Center. CHS sent out invitations and reminders for two of the programs: Hypertension in Diabetes and The Diabetic Foot. (3) CHS sent out memos and related articles to PCPs, NPs, and PAs. (4) CHS Diabetic Study nurse to attend the two-day Arizona State Diabetes Collaborative, Learning Session one. *Feedback*: (1) Care Plans: following CHS's annual chart reviews, SNF DONs were notified of all charts missing diabetic care plans and asked to follow up. (2) CHS's Diabetic Study nurse, in conjunction with the CHS Medical Director, will determine whether the MDS and RAP printouts are adequate, or if a comprehensive Diabetes Care Plan needs to be developed and sent as a Best Practice to skilled nursing facilities. (3) Will continue to send letters to all contracted physicians who do not meet the expectations of the diabetes quality indicators as defined by AHCCCS. System Redesign *Practice Enhancing Forms*: CHS will continue to offer "Best Practice" forms, including diabetic care plans to skilled nursing facilities.
	HbA1c > 9.5	45.5%	24.1%	Yes p=0.004	

Contractor	Indicator	Baseline	Re-measure	Improve?	Interventions
Evercare Select	HbA1c testing	57.0%	50.3%	No, but n.s. p=.243	Patient Interventions *Education*: A1c kits delivered to members in HCBS setting if no A1c obtained in 6 months. Provider Interventions *Reminder*: Health Plan survey delivered or faxed to physician for completion of data of A1c results, blood sugars, fasting lipids, foot exam, retinal eye exam *Education*: Attendance at Arizona State Diabetes Collaborative sessions
	HbA1c > 9.5	49.6%	54.5%	No, but n.s. p=0.400	
Mercy Care Plan	HbA1c testing	44.4%	67.6%	Yes p=0.049	Patient Interventions *Reminders*: Direct telephone contact with members identified as moderate to high-risk. *Education*: Periodic member diabetes newsletters mailed to members with diabetes Provider Interventions *Guidelines*: Updated guidelines as needed in the Provider Manual and on the MCP website *Education*: (1) Information about diabetes in provider newsletter. (2) Interface with home health agency and PCPs for education and assessment. (3) Collaborate providing educational seminars for PCPs regarding managing patients with diabetes. *Feedback*: (1) PCP profiling and feedback. (2) Share findings of CYE03 barrier analysis with providers System Redesign Interventions *Tracking*: (1) Enhance identification of members who are hospitalized. (2) Enhance electronic disease management database to better identify members. (3) High-risk members with diabetes enrolled in diabetes case management. Case managers conduct assessments at visits and do follow-up phone calls.
	HbA1c > 9.5	55.6%	40.0%	Yes, but n.s. p=0.201	

Contractor	Indicator	Baseline	Re-measure	Improve?	Interventions
Pima Health	HbA1c Testing	71.0%	77.1%	Yes, but n.s, p=0.20	Patient Interventions *Education*: QM associates will continue to educate diabetic members through newsletter articles and special mailings. Provider Interventions *Feedback*: PHS case managers get results of the most recent HbA1c and lipid profile as part of the information on their 180 and 90 ay reviews *Education*: QM associates will continue to educate providers through newsletter articles and special mailings. System Redesign Interventions *Tracking*: QM associates will encourage PCPs and providers to use a diabetic flow sheet for all their diabetic patients. PHS pharmacy division is requiring information on the most recent HbA1c and lipid profile as a requirement for PA of non-formulary diabetic drugs.
	HbA1c > 9.5	36.6%	30.3%	Yes, but n.s. p=0.226	
Pinal/Gila County	HbA1c Testing	39.1%	73.0%	Yes P<0.001	Patient Interventions *Reminders*: To members of due screenings with assistance in scheduling if needed *Education*: Diabetes care. Provider Interventions *Reminders*: To providers of due screenings *Education*: Newsletter and a lunch and learn program System Redesign Intervention *Standing orders*: Obtain authorization for DM HHN nurse to draw blood for screens
	HbA1c > 9.5	60.9%	32.4%	Yes p=0.002	
Yavapai County	HbA1c testing	44.8%	64.1%	Yes p=0.025	No interventions found
	HbA1c > 9.5	60.3%	42.3%	Yes p=0.037	

Strengths and Opportunities for Improvement

The strength of this PIP was AHCCCSA's standardization. The following components were standardized by AHCCCSA:
:

- selection of topic;
- development of study questions;
- identification of indicators;
- specification of indictors, including data collection processes and numerator and denominator construction;
- re-measurement processes; and
- data analyses for both baseline and re-measurement.

The procedures for follow-up after the dissemination of re-measurement appear appropriate. The one plan with a decline in performance was required to submit a plan for corrective action.

Summary Conclusions

Interventions undertaken by Contractors included mass mailings, newsletters, and educational conferences. A few Contractors used stronger interventions: one-on-one patient education/contact, real-time provider reminders, audit, and feedback. Two Contractors appear to have undertaken root cause and/or barrier analysis to guide their selection of improvement activities.

Appendix A

Regulations Crosswalks

A1
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
EQR MATRIX OF AREAS FOR REVIEW FY 2005

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
438.10 Information requirements. **(f) General information for all enrollees of MCOs, PIHPs**… information must be made available to MCO, PIHP…enrollees as follows: **(4)**…the MCO, PIHP…must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraph (f)(6) of this section, and, if applicable, paragraphs (g)...of this section at least 30 days before the intended effective date of the change.	X	X	X	X	X	X
(5) The MCO, PIHP...must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	X	X	X	X	X	X
438.100 Enrollee rights (continued). **(b) Specific rights.** **(1)** Basic requirement. The State must ensure that… **(2)** An enrollee of an MCO, PIHP…has the …right to… **(vi)** If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.	X	X	X		X	
438.206(b)(2) Provides female enrollees with direct access to a women' s health specialist within the	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.						
438.206(b)(3) Each MCO, PIHP…consistent with the scope of the PIHPs …contracted services meets the following requirements: **(3)** Provides for a second opinion from a qualified health care professional within the network or arranges for the enrollee to obtain one outside the network at no cost to the enrollee.	X	X	X	X	X	X
438.206(b)(4) Each MCO and PIHP...consistent with the scope of the PIHPs…contracted services meets the following requirements: **(4)** If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP…must adequately and timely cover these services out-of-network for the enrollee, for as long as the MCO, PIHP is unable to provide them.	X	X	X	X	X	X
438.208 Coordination and continuity of care. **(b) Primary care and coordination of health care services for all MCO, PIHP**…enrollees. Each MCO, PIHP…must implement procedures to deliver primary care to and coordinate health care services for all MCO, PIHP…enrollees. These procedures must meet State requirements and must do the following: **(1)** Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
438.208 Coordination and continuity of care. **(b) Primary care and coordination of health care services for all MCO, PIHP.** **(4)** Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	X	X	X	X	X	X
438.208 Coordination and continuity of care. **(c) Additional services for enrollees with SHCNs.** **(4)** Direct Access to Specialists. For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.	X	X	X	X	X	X
438.210 Coverage and authorization of services **(b) Authorization of services.** For the processing of requests for initial and continuing authorizations of services, each contract must require: **(2)** That the MCO, PIHP… **(ii)** Consult with the requesting provider when appropriate. **(3)** That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X X	X X	X X	X (3)	X X	X (3)
438.210 Coverage and authorization of services **(c) Notice of adverse action.** Each contract must	X (provider	X (provider	X (provider	X (provider	X (provider	X (provider

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
provide for the MCO, PIHP…to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP…to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 438.404, except that the notice to the provider need not be in writing.	notification)	notification)	notification)	notification)	notification)	notification)
438.210 Coverage and authorization of services **(e) Compensation for UM activities.** Each contract must provide that, consistent with 438.6(h) and 422.208 of this chapter, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	X	X	X	X	X	X
438.114 Emergency and post-stabilization care services ***(a) Definitions.*** *As used in this section –* *Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in –* ***(1)*** *Placing the health of the individual or with respect to a pregnant woman, the health of the woman, or her unborn child in serious jeopardy.* ***(2)*** *Serious impairment to bodily functions.* ***(3)*** *Serious dysfunction of any bodily organ or part.* *Emergency services means covered inpatient or outpatient services that are –* ***(1)*** *Furnished by a provider that is qualified to furnish these services under this title.* ***(2)*** *Needed to evaluate or stabilize an emergency*	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
medical condition. *Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.*						
438.114 (a) Coverage and payment: General rule. The following entities are responsible for coverage and payment of emergency services and post-stabilization care services. **(1)** The MCO, PIHP… **(c)** Coverage and payment: Emergency services. **(1)** The entities identified in paragraph (b) of this section – **(i)** Must cover and pay for emergency services regardless of whether the entity that furnishes the services has a contract with the MCO, PIHP…and **(ii)** May not deny payment for treatment obtained under either of the following circumstances: **(A)** An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section. **(B)** A representative of the MCO, PIHP. . . instructs the enrollee to seek emergency services.	X	X	X	X	X	X
(d) Additional rules for emergency services. **(1)** The entities specified in paragraph (b) of this section may not- **(i)** Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms.	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(ii) Refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the enrollee's PCP, MCO, PIHP...or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. **(2)** An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. **(3)** The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identifying paragraph (b) of this section as responsible for coverage and payment.						
(e) Coverage and payment: Post-stabilization care services. Post-stabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of this chapter. In applying those provisions, reference to "M+C organization" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section. **(f) Applicability to** PIHPs…To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP…is responsible, the rules under this section apply.	X	X	X	X	X	X
438.214 Provider selection. **(c) Nondiscrimination**. MCO, PIHP...provider selection P&Ps, consistent with §438.12 **(below)** do not discriminate against particular practitioners that serve high-risk populations, or specialize in conditions that require costly treatment.	X	X	X	X	X	X
438.12 Provider discrimination prohibited.	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(a) General rules. **(1)** An MCO, PIHP...may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO, PIHP...declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. **(2)** In all contracts with health care professionals, an MCO, PIHP... must comply with the requirements specified in §438.214.						
438.214: Provider selection. **(d) Excluded providers.** MCOs, PIHPs...may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	X	X	X	X	X	X
438.230 Subcontractual relationships and delegation. **(a) General rule.** The State must ensure, through its contracts, that each MCO, PIHP... **(1)** Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor. **(b) Specific conditions.** **(1)** Before any delegation, each MCO or PIHP evaluates the prospective subcontractor's ability to perform the activities to be delegated. **(2)** There is a written agreement that: **(i)** Specifies the activities and report responsibilities designated to the subcontractor. **(ii)** Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. **(3)** The MCO or PIHP monitors the subcontractor's	X	X	X	X	X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. **(4)** If any MCO or PIHP identifies deficiencies or areas for improvement, the MCO or PIHP and the subcontractor take corrective action.						
438.236 Practice guidelines. **(a) Basic rule.** The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP... meets the requirements of this section. **(b) Adoption of practice guidelines.** Each MCO and, when applicable, each PIHP... adopts practice guidelines that meet the following requirements: **(1)** Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. **(2)** Consider the needs of the MCO's, PIHP's...enrollees. **(3)** Are adopted in consultation with contracting health care professionals. **(c) Are reviewed and updated periodically**, as appropriate.	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005
438.236 Practice guidelines. **(c) Dissemination of guidelines.** Each MCO, PIHP...disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005	Were reviewed, but will be more extensively reviewed in FY 2005
438.236 Practice guidelines. **(d) Application of guidelines.** Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	X	X	X	X	X	X
438.240 Quality assessment and PIP. **(a) General rules.**				X		X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(1) The State must require, through its contracts, that each MCO and PIHP has an ongoing quality assessment and PIP for the services it furnishes to its enrollees.						
438.406 Handling of grievances and appeals. **(a) General requirements**. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements. **(3)** Ensure that the individuals who make decisions on grievances and appeals are individuals. **(i)** Who were not involved in any previous level of review or decision-making. **(ii)** Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease. **(A)** An appeal of a denial that is based on lack of medical necessity. **(B)** A grievance regarding denial of expedited resolution of an appeal. **(C)** A grievance or appeal that involves clinical issues.	X	X	X		X	
438.406 Handling of grievances and appeals. **(b) Special requirements for appeals.** The process for appeals must: **(1)** Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or provider requests expedited resolution. **(2)** Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)	X	X	X		X	

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process. **(4)** Include, as parties to the appeal: **(i)** The enrollee and his or her representative. **(ii)** The legal representative of a deceased enrollee's estate.						
438.408 Resolution and notification: Grievances and appeals. **(c) Extension of time frames.** **(1)** The MCO or PIHP may extend the time frames from paragraph (b) of this section by up to 14 calendar days if: **(i)** The enrollee requests the extension. **(ii)** The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the delay is in the enrollee's interest. **(2)** Requirements following extension. If the MCO or PIHP extends the time frames, it must – for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.	X	X	X		X	
438.408 Resolution and notification: Grievances and appeals. (**d) Format of notice.** (**2**) Appeals: **(i)** For all appeals, the MCO or PIHP must provide written notice of disposition. **(ii)** For notice of expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.	X	X	X		X	
438.410 Expedited resolution of appeals. **(b) Punitive Action.** The MCO or PIHP must ensure	X	X	X		X	X

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal. **(c) Action following denial of a request for expedited resolution.** If the MCO or PIHP denies a request for expedited resolution of an appeal, it must: **(1)** Transfer the appeal to the time frame for standard resolution in accordance with 438.408(b)(2). **(2)** Make reasonable effort to give the enrollee prompt oral notice of the denial, and follow up within 2 calendar days with a written notice.				X (b) only		
438.414 Information about the grievance system to providers and subcontractors. The MCO or PIHP must provide the information specified at 438.10(g)(1) [restated below] about the grievance system to all providers and subcontractors at the time they enter into a contract. ***§438.10(g)(1)*** *Grievance, appeal ... procedures, and time frames, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include:* ***(i)*** *. . . (Requirement applies only to the State.)* ***(ii)*** *The right to file grievances and appeals.* ***(iii)*** *The requirements and time frames for filing a grievance or appeal.* ***(iv)*** *The availability of assistance in the filing process.* ***(v)*** *The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.*	X	X	X	X	X	X
438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending. **(a) Terminology**. As used in this section, "timely" filing means filing on or before the later of the following: **(1)** Within 10 days of the MCO or PIHP mailing the NOA.	X	X	X		X	

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(2) The intended effective date of the MCO's or PIHP's proposed action. **(b) Continuation of benefits**. The MCO or PIHP must continue the enrollee's benefits if: **(1)** The enrollee or the provider files the appeal timely. **(2)** The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. **(3)** The services were ordered by an authorized provider. **(4)** The original period covered by the original authorization has not expired. **(5)** The enrollee requests extension of benefits. **(c) Duration of continued or reinstated benefits.** If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: **(1)** The enrollee withdraws the appeal. **(2)** Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day time frame, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.						

Protocol Standard Subpart C Regulations: Enrollee Rights and Protections	Cochise Health	Evercare Select	Mercy Care Plan	Pima Health	Pinal/Gila County	Yavapai County
(3) A State fair hearing office issues a hearing decision adverse to the enrollee. **(4)** The time period or service limits of a previously authorized service has been met. **(d) Enrollee responsibility for services furnished while the appeal is pending.** If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 431.230(b) of this chapter**.** **(431.230 Maintaining services.** ***(b)*** *If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.***)**	X	X	X		X	
438.424 Effectuation of reversed appeal resolutions. **(a) Services not furnished while the appeal is pending**. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires. **(b) Services furnished while the appeal is pending.** If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.	X	X	X	X	X	X

CONTRACTOR NAME: (ALTCS) CYE 2004 – 10/01/03 – 9/30/04

A2

AHCCCSA EQR RESULTS REVIEW - CROSSWALK WITH BBA

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.100 Enrollee Rights (a) General Rule (1), (2)		Y – CYE 04	Tab B; AM 1.1 – 1.7 Tab B; GA 1.0
§438.100 Enrollee Rights (b) Specific rights (1), (2) (i)		Y – CYE 04	Tab B; AM 1.1 – 1.7 Tab B; GA 1.0 & Tab D
	§438.10		
	(b) Basic rule	Y – CYE 04	Tab F
	(c) Language	Y – CYE 04	Tab B; AM 4.1 – 4.5; Tab D
	(3)	Y - CYE 04	Tab B; AM 4.1 – 4.5; Tab D
	(4)	Y - CYE 04	Tab B; AM 4.1 – 4.5; Tab D
	(5) (i), (ii)	Y - CYE 04	Tab B; AM 4.1 – 4.5; Tab D
	(d) Format	Y – CYE 04	Tab D; Tab F
	(1) (i), (ii)	Y – CYE 04	Tab B AM 3.1 – 3.2; Tab D
	(2)	Y – CYE 04	Tab B AM 3.1 – 3.2; Tab D
	(f) General information…		
	(2)	Y – CYE 04	Tab D
	(3)	Y – CYE 04	Tab D
	(4)	N – CYE 05	
	(5)	N – CYE 05	
	(6) (i), (ii),(iii), (iv), (v), (vi), (vii), (viii) (A), (B), (C), (D), (E), (ix), (x), (xi), (xii)	Y – CYE 04	Tab D
	(g) Specific Information…	Y – CYE 04	Tab D
	(1) (i), (A), (B), (C), (ii), (iii), (iv), (v), (vi), (A), (B), (vii) (2), (3),	Y – CYE 04	Tab D

	(i) Special rules… (1) (2) (3) (i), (ii), (iii), (iv)	N/A	
§438.100 Enrollee Rights (b) Specific rights (2) (i), (ii), (iii), (iv), (v), (vi)		Y – CYE 04	Tab D

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.100 Enrollee Rights			
(b) Specific rights (3)			
	§438.206		
	(b) Delivery network	Y – CYE 04	Tab E
	(1) (i), (ii), (iii), (iv), (v)	Y – CYE 04	Tab E
	(2)	N – CYE 05	
	(3)	N – CYE 05	
	(4)	N – CYE 05	
	(5)	N/A	
	(c) Furnishing of services		
	(1) (i), (ii), (iii), (iv), (v), (vi)	Y – CYE 04 Y – CYE 04	Tab B - AM 10.1-10.2; BH 5.0; DS 2.2
	(2)		Tab B – AM 3.0-4.0; Tab D
	§438.208		
	(b) Primary care…	N – CYE 05	
	(1)	N/A	
	(2)	N/A	
	(3)	N – CYE 05	
	(4)		
	(c)Additional services…	N/A	
	(1) (i), (ii)	Y – CYE 04	
	(2)	N/A	TAB B, QM 1.1
	(3) (i), (ii), (iii)	N – CYE 05	
	(4)		
	§438.210		Tab B – UM/ PA 1.1–1.3
	(b) Authorization of…	Y – CYE 04	Tab B – UM/ PA 1.1–1.3

	(1) (2) (i), (ii) (3) (c) Notice of …. (d) Timeframe for… (2) (i), (ii) (3) (i), (ii) (e) Compensation for …	Y – CYE 04 N – CYE 05 Enrollees – Y – CYE 04 Providers – N – CYE 05 Y – CYE 04 Y – CYE 04 N – CYE 05	Tab B, AM 1.1-1.7 Tab B – UM/PA 1.2 Tab B – UM/PA 1.2

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.100 Enrollee Rights (c) Free exercise…..		Y – CYE 04	Tab D
§438.100 Enrollee Rights (d) Compliance with…..		Y – CYE 04	Tab B, OFR
§438.114 Emergency and Post –stabilization services		N – CYE 05	
§438.214 Provider selection			
§438.214 Provider selection (a) General rules		Y – CYE 04	Tab B, QM 2.1-2.2
§438.214 Provider selection (b) Credentialing…. (1), (2)		Y – CYE 04 Y – CYE 04	Tab B, QM 2.1-2.2 Tab B, QM 2.1-2.2
§438.214 Provider selection (c) Nondiscrimination	§438.12 (a) (1), (2) (b) (1), (2), (3)	N – CYE 05 N – CYE 05 N/A	
§438.214 Provider selection (d) Excluded ….		N – CYE 05	
§438.214 Provider selection (e) State requirements.		Y – CYE 04	Tab B, OFR
§438.226 Enrollment…..		N/A	
§438.228 Grievance Systems (a) (b)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0–2.0 Tab B, AM 1.1-1.7
§438.230 Subcontractual ….			

§438.230 Subcontractual (a) General rule (1) (2)		 N – CYE 05 N – CYE 05 N – CYE 05	

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.230 Subcontractual (b) Specific conditions (1) (2) (i), (ii) (3) (4)		 N – CYE 05 N – CYE 05 N – CYE 05 N – CYE 05 N – CYE 05	
§438.236 Practice guidelines			
§438.236 Practice guidelines		Y – CYE 04	Tab B, UM-1.3; will be more extensively reviewed in CYE 05
§438.236 Practice Guidelines (b) Adoption of…. (1) (2) (3) (4)		 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B, UM-1.3; will be more extensively reviewed in CYE 05 Tab B, UM-1.3; will be more extensively reviewed in CYE 05 Tab B, UM-1.3; will be more extensively reviewed in CYE 05 Tab B, UM-1.3; will be more extensively reviewed in CYE 05
§438.236 Practice guidelines (c) Dissemination ….		Y – CYE 04	Tab B, UM-1.3; will be more extensively reviewed in CYE 05
§438.236 Practice guidelines (d) Application of guidelines		N – CYE 05	
§438.240 Quality assessment…			
§438.240 Quality assessment… (a) General rules			

(1)		N – CYE 05	
§438.240 Quality assessment… (b) Basic elements (1) (2) (3) (4)		 Y – CYE 04 Y – CYE 04 Y – CYE 04 N/A	 Tab B, QM-4.0-5.0 Tab B, QM-4.0-5.0 Tab B, UM -1.2

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.240 Quality assessment… (c) Performance measurements (1) (2) (3)	§438.204 (c) §438.240 (a)(2)	Y – CYE 04 Y – CYE 04 Y – CYE 04	See Binder 12 for (1), (2), and (3); Tabs 2 through 13
§438.240 Quality assessment… (d) Performance improvement (1) (i), (ii), (iii), (iv) (2)	§438.240 (a)(2)	Y – CYE 04 Y – CYE 04	See Binder 12 for (1) and (2); Tabs E through I
§438.240 Quality assessment… (e) Program review… (2) (i), (ii) (3)		Y – CYE 04 Y – CYE 04	See Binder 12 for (2) and (3); Tabs A through D and tabs 14 through 29
§438.242 Health information systems			
§438.242 Health information systems (a) General rule		Y – CYE 04	Tab B, QM-3.0; GA 1.0-2.0
§438.242 Health information systems (b) Basic elements…. (1) (2)(i), (ii), (iii)		Y – CYE 04	Tab B, ENC et al, FM 1.1-1.3, QM 4.0-5.0 Tab B, ENC et al, FM 1.1-1.3, QM 4.0-5.0

(3)			Tab B, ENC et al, FM 1.1-1.3, QM 4.0-5.0
§438.402 General requirements			
§438.402 General requirements (a) The grievance….		Y – CYE 04	Tab B, AM 1.1-1.7; GA 1.0-2.0
§438.402 General requirements (b) Filing requirements (1) (i), (ii) (2) (i), (ii) (3) (i), (ii)		 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B, AM-1.1.-1.7; GA 1.0-2.0 Tab B, AM-1.1.-1.7; GA 1.0-2.0 Tab B, GA 1.0-2.0

Primary Regulation §438.404 Notice of action	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.404 Notice of action (a) Language….		Y – CYE 04	Tab B, AM-1.1.-1.7; GA 1.0-2.0
	§438.10 (c) language (3) (4) (5) (i), (ii) (d) Format (2) (i), (ii) (3)	 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B; AM 4.1 – 4.5; Tab D Tab B; AM 4.1 – 4.5; Tab D Tab B; AM 4.1 – 4.5; Tab D Tab D; Tab F Tab B AM 3.1 – 3.2; Tab D Tab B AM 3.1 – 3.2; Tab D
§438.404 Notice of action (b) Content of …. (1) (2) (3) (4) (5) (6) (7)		 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0 Tab B, AM-1.1-1.7; GA 1.0-2.0

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.404 Notice of action			
(c) Timing of ….			
(1)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	§431.211	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	§431.213	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(a)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(b) (1), (2)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(c)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(d) §431.231		
	(d)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(e)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(f)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(g)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(h)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	§431.214		
	(a)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
	(b)	Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
(2)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
(3)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
(4) (i), (ii)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
(5)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
(6)		Y – CYE 04	Tab B, AM-1.1-1.7; GA 1.0-2.0
§438.406 Handling of grievance and appeals			
§438.406 Handling			
(a) General requirements			
(1)		Y – CYE 04	Tab B, GA 1.0-2.0
(2)		Y – CYE 04	Tab B, GA 1.0-2.0

(3) (i), (ii) (A), (B), (C)		Y – CYE 04	Tab B, GA 1.0-2.0
§438.406 Handling (b) Special requirement… (1) (2) (3) (4) (i), (ii)		 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0

Primary Regulation §438.408 Resolution and notification	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.408 Resolution and notification (a) Basic rule		Y – CYE 04	Tab B, GA 1.0-2.0; QM 3.0
§438.408 Resolution and notification (b) Specific timeframes (1) (2) (3)		Y – CYE 04 Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0; QM 3.0 Tab B, GA 1.0-2.0; QM 3.0 Tab B, GA 1.0-2.0; QM 3.0
§438.408 Resolution and notification (c) Extension of timeframes (1) (i), (ii) (2)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0; QM 3.0 Tab B, GA 1.0-2.0; QM 3.0
§438.408 Resolution and notification (d) Format of notices (1) (2) (i), (ii)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0, QM 3.0 Tab B, GA 1.0-2.0
§438.408 Resolution and notification (e) Content of notices…. (1) (2) (i), (ii), (iii)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0
§438.408 Resolution and			

notification (f) Requirements for State…. (1) (i), (ii) (2)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0
§438.410 Expedited resolution of appeals			
§438.410 Expedited resolution of …. (a) General rule		Y – CYE 04	Tab B, GA 1.0-2.0
§438.410 Expedited resolution of …. (b) Punitive action		N – CYE 05	
§438.410 Expedited resolution of …. (c) Action following…. (1) (2)		Y – CYE 04 Y – CYE 04	Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0

Primary Regulation	*Secondary Regulation*	*Covered Y/N and CYE*	*Reference*
§438.414 Information about the grievance system to providers and subcontractors	§438.10 (g) (1) (i), (ii), (iii), (iv), (v)	N – CYE 05	
§438.416 Recordkeeping and reporting requirements		Y – CYE 04	Tab B, GA 1.0-2.0, QM 3.0
§438.420 Continuation of Benefits			
§438.420 Continuation of Benefits while the MCO or PIHP appeal and the State fair hearing are pending		Y – CYE 04	Tab B, GA 1.0-2.0, QM 3.0
§438.420 Continuation of …. (a.) Terminology (1) (2)		 Y – CYE 04 Y – CYE 04	 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0
§438.420 Continuation of …. (b) Continuation of … (1) (2) (3) (4) (5)		 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04 Y – CYE 04	 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0 Tab B, GA 1.0-2.0
§438.424 Effectuation of reversed appeal resolution			
§438.424 Effectuation of … (a) Services not ….		N – CYE 05	
§438.424 Effectuation of … (b) Services furnished ….		N – CYE 05	

Appendix B

AHCCCSA Review Documents

ALTCS OPERATIONAL AND FINANCIAL REVIEW
Contract Year Ending 2004

AHCCCS

Conducted by:

Division of Health Care Management Office of Legal Assistance

TABLE OF CONTENTS

6. ALTCS FACT SHEET 1

7. PROGRAM CONTRACTOR FACT SHEET 1

8. EXECUTIVE SUMMARY 1

9. FINDINGS 3

10. ADMINISTRATION AND MANAGEMENT 4

11. BEHAVIORAL HEALTH 18

12. DELIVERY SYSTEM 23

13. ENCOUNTERS 29

14. FINANCIAL MANAGEMENT 37

15. GRIEVANCE AND APPEALS 44

16. CASE MANAGEMENT 47

17. QUALITY MANAGEMENT 52

18. UTILIZATION MANAGEMENT 59

19. MEDICAL DIRECTION.....66

20. ANALYSIS OF CORRECTIVE ACTION PLAN FROM PREVIOUS REVIEW 70

ALTCS FACT SHEET

Arizona Health Care Cost Containment System
Arizona Long Term Care System
701 East Jefferson Street; MD 6100
Phoenix, Arizona 85034
Tel: (602) 417-4000

AHCCCS REVIEW TEAM

Alan Schafer, ALTCS Manager, DHCM
John Black, ALTCS Operations and Compliance Coordinator, DHCM
P.J. Schoenstene, ALTCS Operations and Compliance Coordinator, DHCM
Patrice Spencer, ALTCS Financial Manager, DHCM
Debra Brown, M.D., Medical Director
Kim Elliott, Clinical Quality Management Administrator, DHCM
Susan Luark, R.N., ALTCS Clinical Quality Management Manager, DHCM
Carol Sanders, Case Management Manager, DHCM
Alonzo Janson, Human Services Specialist, DHCM
Shirley Manchek, R.N., Medical Services Program Review Specialist, DHCM
Olga Wolf, R.N., ALTCS Clinical Quality Management, DHCM
Erin Bringardner, Programs and Projects Specialist, DHCM
Kim Carter, Hearing Officer, OLA

Joseph Ruiz, Hearing officer, OLA

PROGRAM CONTRACTOR FACT SHEET

Contractor Name
Address
Address

PROGRAM CONTRACTOR STAFF

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System's (AHCCCS) mission is to provide comprehensive, quality health care for those in need. In fulfilling this responsibility, AHCCCS reviews the operational and financial performance of contracted Program Contractors on a regular basis.

The primary objectives of **Program Contractor Name Year** contract year ending 2004(CYE 04) are to:

- Perform Program Contractor oversight as required by the Health Care Financing Administration in accordance with AHCCCS' 1115 waiver.
- Determine if the Program Contractor satisfactorily meets AHCCCS' requirements as specified in the CYE 04 RFP, AHCCCS policies and the Arizona Administrative Code (AAC).
- Determine if the Program Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Increase AHCCCSA knowledge of the Program Contractor's operational and financial procedures.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.

The CYE 04 Review Team included the Division of Health Care Management (DHCM)) Program Contractor Operations, Research, Financial Management, and Behavioral Health staff, Quality Management and Case Management Services Review staff, and Office of Legal Assistance (OLA) staff. The on-site document review and staff interviews were conducted at the Program Contractor's office **Date**. The report contains specific and detailed findings and recommendations.

Program Contractor Name serves eligible enrolled members in **Geographic Service Areas.** The Program Contractor has contracted with the Arizona Health Care Cost Containment System (AHCCCS) since **Date**. At the time of this review, the Program Contractor had approximately **Number** Title XIX members,

The Review Team performed an extensive document review and conducted interviews with appropriate Program Contractor personnel. A brief summary and performance assessment of each program area follows:

Administration and Management:

Behavioral Health:

Delivery System:

Encounters:

Financial Management:

Grievance and Appeals:

Member Services/Case Management:

Quality Management:

Utilization Management:

Medical Direction

FINDINGS

Rating Definitions

All of the standards are rated based on the percentage of the findings that meet the standard. The ranges are defined below.

Full Compliance: The Program Contractor is 90-100% in compliance with the standard or sub-standard.

Substantial Compliance: The Program Contractor is 75-89% in compliance with the standard or sub-standard.

Partial Compliance: The Program Contractor is 50-74% in compliance with the standard or sub-standard.

Non-Compliance: The Program Contractor is 0-49% in compliance with the standard or sub-standard.

Recommendation Definitions

The Program Contractor must...This indicates a critical non-compliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.

The Program Contractor should...This indicates a non-compliance area that must be corrected to be in compliance with the AHCCCS contract but it is not critical to the every day operations of the Program Contractor.

The Program Contractor should consider......This is a suggestion by the Review Team to improve operations of the Program Contractor, although it is not directly related to contract compliance.

ADMINISTRATION AND MANAGEMENT

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

ADMINISTRATION AND MANAGEMENT:

STANDARDS	FINDINGS	RECOMMENDATIONS
AM 1.1		
AM 1.2		
AM 1.3		
AM 1.4		
AM 1.5		
AM 1.6		
AM 2.1		
AM 2.2		
AM 3.1		
AM 3.2		

AM 4.1		
AM 4.2		
AM 4.3		
AM 4.4		
AM 4.5		
AM 5.1		
AM 5.2		
AM 5.3		
AM 6.0		
AM 7.0		
AM 8.0		
AM 9.0		
AM 10.1		
AM 10.2		
AM 11.1		
AM 11.2		
AM 11.3		

FC = Full Compliance 90-100%
SC = Substantial Compliance 75-89%
PC = Partial Compliance 50-74%
NC = Non-Compliance 0-49%
IO = Information Only

ADMINISTRATION AND MANAGEMENT

AM 1.0 **The Program Contractor complies with all Member Rights and Responsibilities Requirements. CYE04 Renewal, Section D. ¶22.**

AM 1.1

CYE04: CYE03:

Standard: **The Program Contractor monitors its prior authorization staff and its case managers to ensure that member rights and responsibilities notification requirements are met.**

Finding(s):
- The Program Contractor does/does not monitor its prior authorization staff to ensure that member rights and responsibilities notification requirements are met.
- The Program Contractor does/does not train its prior authorization staff to ensure that member rights and responsibilities notification requirements are met.
- The Program Contractor does/does not monitor its case managers to ensure that member rights and responsibilities notification requirements are met.
- The Program Contractor does/does not train its case managers to ensure that member rights and responsibilities notification requirements are met.

Comment(s):
Recommendation(s):

AM 1.2

CYE04: CYE03:

Standard: **Members are notified in a timely manner of their rights and responsibilities when there is a denial of a service requiring authorization.**

Finding(s):
- In () out of () (%) files reviewed, members were sent a "Notice Of Our Decision About Your Request For Health Services" form no later than 3 business days from the date when the authorization for requested service was denied.

Comment(s):
Recommendation(s):

AM 1.3

CYE04: CYE03:

Standard: **Members are notified in a timely manner of their rights and responsibilities when there is a reduction, suspension or termination of a HCBS service requiring authorization.**

Finding(s):
- In () out of () (%) files reviewed, members were provided with a "Notice Of Our Decision To Change Your Health Services" form at least 10 days prior to the date a service was to be reduced, suspended or terminated.

Comment(s):

Recommendation(s):

AM 1.4

CYE04: CYE03:

Standard: **The "Notice of Intended Action" forms give a specific reason for the intended action.**

Finding(s):
- In () out of () acute care "Notice of Intended Action" forms reviewed, the Program Contractor gave specific reason for the intended action.
- In () out of () HCBS "Notice of Intended Action" forms reviewed, the Program Contractor gave specific reason for the intended action.

Comment(s):

Recommendation(s):

AM 1.5

CYE04: CYE03:

Standard: **The "Notice of Intended Action" forms uses commonly understood language.**

Finding(s):
- In () out of () (%) acute care forms reviewed, the language the Program Contractor used to describe the reasons for denial, reduction, suspension or termination of service was in commonly understood language appropriate for a lay person.

- In () out of () (%) HCBS forms reviewed, the language the Program Contractor used to describe the reasons for denial, reduction, suspension or termination of service was in commonly understood language appropriate for a lay person.

Comment(s):

Recommendations(s):

AM 1.6

CYE04: CYE03:

Standard: **The deadlines for filing grievances and appeals on the Member Rights and Responsibilities forms are correctly calculated.**

Finding(s):

- In () out of () (%) acute care forms reviewed, the Program Contractor correctly calculated grievance and appeal dates.
- In () out of () (%) HCBS forms reviewed, the Program Contractor staff correctly calculated grievance and appeal dates.

Comment(s):

Recommendation(s):

AM 2.0 **The Program Contractor has a Business Continuity Plan that meets AHCCCS requirements.**

CYE04 Renewal, Section D. ¶83.

AM 2.1

CYE04: CYE03:

Standard: **The Program Contractor has a Business Continuity Plan.**

Finding(s):
- The Program Contractor does/does not have a Business Continuity Plan.
- The Business Continuity Plan is/is not reviewed annually.
- Staff are/are not trained and familiar with the Business Continuity Plan.
- The Business Continuity Plan includes planning and training that is specific for the Program Contractor (e.g., not generic to the corporation or county) and includes the following:
  - Healthcare facility closure/loss of major provider
  - Electric/telephonic failure at the main site
  - Loss of primary computer system/records
  - How the Program Contractor will communicate with AHCCCS

Comment(s):
Recommendation(s):

INFORMATION ONLY

AM 2.2

Standard: **The Program Contractor tests its Business Continuity Plan.**

Finding(s):
- The Program Contractor does/does not periodically test its Business Continuity Plan.

Comment(s):
Recommendation(s):

AM 3.0 The Program Contractor provides members with written materials in appropriate languages.

CYE04 Renewal, Section D. ¶17.

AM 3.1

CYE04: CYE03:

Standard: **The Program Contractor has assessed the non-English language needs of its limited English proficiency (LEP) membership.**

Finding(s):
- The Program Contractor has/has not assessed the language needs of its population to determine the number of LEP members who speak/read a language other than English.
- Action has/has not been taken as the result of the assessment of language needs.

Comment(s):
Recommendation(s):

AM 3.2

CYE04: CYE03:

Standard: **The Program Contractor translates all written materials for each LEP language group that constitutes 5% or 1,000 (whichever is less) of the Program Contractor's membership.**

Finding(s):
- The Program Contractor does/does not translate all written materials for each LEP language group when membership thresholds are met.

Comment(s):
Recommendation(s):

AM 4.0 The Program Contractor has a Cultural Competency Plan which meets AHCCCS requirements.

CYE04 Renewal, Section D. ¶69.

AM 4.1

CYE04: CYE03:

Standard: **The Program Contractor has implemented its Cultural Competency Plan.**

Finding(s):
- The Program Contractor can/cannot demonstrate that it has contracts or other arrangements with interpretation service providers to service its members.
- The Program Contractor has/has not educated providers about how to obtain interpreter services for members who utilize their services.
- The Program Contractor tracks/does not track provider's utilization of interpretation services.

- The Program Contractor has/has not educated employees (CM) about how to obtain interpreter services for members who utilize their services.

Comment(s):
Recommendation(s):

AM 4.2

CYE04: CYE03:

Standard: **The Program Contractor conducted an annual evaluation of its Cultural Competency Plan and a copy of the evaluation was sent to the Division of Health Care Management.**

Finding(s):
- The Program Contractor has/has not conducted an evaluation of its Cultural Competency Plan.
- The PC took/did not take action when evaluation showed a trend/need.
- The PC sent/did not send a copy of the annual evaluation to OMC.

Comment(s):
Recommendation(s):

AM 4.3

CYE04: CYE03:

Standard: **The Program Contractor has an ongoing education program about providing culturally competent services.**

Finding(s):
- The Program Contractor has/has not oriented its providers how to provide culturally competent services.
- The Program Contractor has/does not have an ongoing education program for providers about how to provide culturally competent services.

Comment(s):
Recommendation(s):

AM 4.4

CYE04: CYE03:

Standard: **The Program Contractor has provided cultural competent education to its employees.**

Finding(s):
- The Program Contractor has/has provided a cultural competency orientation to its employees.
- The Program Contractor has/does not have an ongoing cultural competent education-training program.

Comment(s):
Recommendation(s):

AM 4.5

CYE04: CYE03:

Standard: **The Program Contractor has taken steps to provide culturally competent services to its members**

Finding(s):
- The Program Contractor can/cannot demonstrate that the enrollment packages includes instructions about obtaining culturally competent materials as well as translation and interpretation services.
- Members have/have not been provided ongoing information about the availability of culturally competent services.

Comment(s):
Recommendation(s):

AM 5.0 The Member Provider Council meets AHCCCS requirements. CYE04 Renewal, Section D. ¶24.

AM 5.1

CYE04: CYE03:

Standard: **The Program Contractor has a Member Provider Council.**

Finding(s):
- The Program Contractor does/does not have a Member Provider Council.
- The Council does/does not meet at least quarterly.
- The Program Contractor has/has not submitted an annual plan.
- The Program Contractor has/has not copied AHCCCS on all correspondence.

Comment(s):
Recommendation(s):

AM 5.2

CYE04: CYE03:

Standard: **The Program Contractor's Member Provider Council reflects a cross representation of the population and community it serves.**

Finding(s):
- The Program Contractor's quarterly meetings of the Member Provider Council does/does not include: members/families/significant others advocacy groups providers (NF, ALH, ALC, Acute, HCBS) (Finding is weighted 50% if quarterly meetings do not include a cross representation of population and community)
- The Program Contractor are/are not taking steps to ensure that attendance at meetings reflects a cross representation of the population and community.

Comment(s):
Recommendation(s):

AM 6.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that ADHS licensed providers submit to the Program Contractor their most recent ADHS license, survey and copies of substantiated complaints. CYE04 Renewal, Section D. ¶33.**

Finding(s):
- The Program Contractor does/does not require in contract that copies of licenses, surveys and

substantiated complaints be submitted.
- Action has/has not been taken as a result of receipt of this information.

Comment(s):
Recommendation(s):

AM 7.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that nursing facilities have procedures in place to ensure that temporary nursing care registry personnel are properly certified and licensed.**
CYE04 Renewal, Section D. ¶33.

Finding(s):
- The Program Contractor does/does not have in subcontracts that nursing facilities must have procedures in place to ensure temporary nursing care registry personnel are properly certified and licensed.
- The Program Contractor does/does not monitor its subcontracted nursing facilities to ensure compliance with this requirement.

Comment(s):
Recommendation(s):

AM 8.0

CYE04: CYE03:

Standard: **The Program Contractor monitors Patient Trust Accounts.**
CYE04 Renewal, Section D. ¶67.

Finding(s):
- The Program Contractor does/does not have a policy regarding on-site monitoring of trust fund accounts for institutionalized members to ensure that expenditures from a member's trust fund comply with federal and state regulations.
- The Program Contractor does/does conduct regular on-site monitoring of trust fund accounts for institutionalized members.
- Action has/has not been taken as the result of regular monitoring.

Comment(s):
Recommendation(s):

AM 9.0

CYE04: CYE03:

Standard: **The Program Contractor shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements**
CYE04 Renewal, Section D. ¶25.

Finding(s):
- The Program Contractor does/does not have a mechanism to ensure that its employees have not been debarred, suspended or otherwise lawfully prohibited from participating in the Medicaid Program.

.

Comment(s):
Recommendation(s):

AM 10.0 **The Program Contractor ensures that appointment standards are met.**
CYE04 Renewal, Section D. ¶38.

AM 10.1

CYE04: CYE03:

Standard: **The Program Contractor ensures that routine care PCP appointments are available within 21 days of request.**

Finding(s):
- Routine care PCP appointments are/are not available within 21 days of request.
- The Program Contractor monitoring reports show that routine care PCP appointment are available within _____ days of request.

Comment(s):
Recommendation(s):

AM 10.2

CYE04: CYE03:

Standard: **The Program Contractor ensures that routine care specialty appointments are available within**

30 days of referral.

Finding(s):
- Routine specialty care appointments are/are not available within 30 days of referral.
- The Program Contractor's monitoring reports show that routine care specialty appointments are available within _____ days of referral.

Comment(s):
Recommendation(s):

AM 11.0 **The Program Contractor has a Corporate Compliance Program.**
CYE04 Renewal, Section D. ¶70.

AM 11.1

CYE04: CYE03:

Standard: **The Program Contractor ensures that its Corporate Compliance Program meets AHCCCS contractual requirements.**

Finding(s):
- The Program Contractor does/does not have an established/published set of policies and procedures or guidelines for the operation of the corporate compliance officer position.
- The Program Contractor has/has not designated a person as a corporate compliance officer.
- The Corporate Compliance Officer does/does not have autonomy in conducting investigations and discussing with staff.

Comment(s):
Recommendation(s):

AM 11.2

CYE04: CYE03:

Standard: **The Program Contractor educates members, providers, and staff on fraud and abuse.**

Finding(s):
- The Program Contractor has/has not educated staff on the Corporate Compliance Program.
- The Program Contractor has/has not provided written information to its members regarding fraud

and abuse.

- The Program Contractor has/has not provided written information to its providers regarding fraud and abuse.

Comment(s):
Recommendation(s):

BEHAVIORAL HEALTH

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

BEHAVIORAL HEALTH

STANDARDS	FINDINGS	RECOMMENDATIONS
BH 1.0		
BH 2.0		
BH 3.0		
BH 4.0		
BH 5.0		
BH 6.0		
BH 7.0		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**

BEHAVIORAL HEALTH

BH 1.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that all behavioral health services provided are medically-necessary.**
CYE04 Renewal, Section D. ¶12.

Finding(s):
- The Program Contractor has/does not have a process for determining the medically necessary services needed by members, as determined by a qualified behavioral health professional.

Comment(s):

Recommendation(s):

BH 2.0

CYE04: CYE03:

Standard: **The Program Contractor shall ensure that care is coordinated with the PCP and with other involved agencies and parties.**
CYE04 Renewal, Section D. ¶12.

Finding(s):
- The Program Contractor does/does not monitor to ensure that behavioral health services are provided in coordination with the member's primary care physician.
- The Program Contractor does/does not monitor to ensure that behavioral health services are provided in coordination with other involved agencies and parties.

Comment(s):

Recommendation(s):

BH 3.0

CYE04: CYE03:

Standard: **The Program Contractor shall develop and maintain a provider network that is accessible and sufficient to provide all covered behavioral health services to ALTCS members.**
CYE04 Renewal, Section D. ¶28.

Finding(s):
- The Program Contractor does/does not monitor and evaluate the accessibility of behavioral health services.
- The Program Contractor does/does not have a process for determining the type and amount of behavioral health services needed.
- The Program Contractor does/does not develop and/or modify the provider network once a need is identified.

Comment(s):
Recommendation(s):

BH4.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that children receive required Well-Child EPSDT developmental/behavioral health screenings and are referred to behavioral health services as appropriate.**
CYE04 Renewal, Section D. ¶10.

Finding(s):
- The Program Contractor does/does not screen for behavioral health needs for EPSDT members.
- The Program Contractor does/does not have a mechanism in place to ensure that a referral has been made when a behavioral health need has been identified.
- The Program Contractor does/does not have a mechanism in place to monitor whether EPSDT members referred for behavioral health services have received services.

Comment(s):
Recommendation(s):

BH 5.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that covered behavioral health services are provided in a timely manner.**
CYE04 Renewal, Section D. ¶38.

Finding(s):
- The Program Contractor does/does not monitor and evaluate its providers compliance with the following appointment standards for behavioral health services:
- Emergency appointments within 24 hours of referral, and
- Routine appointments, including psychiatric appointments, within 30 days of referral.

Comment(s):

Recommendation(s):

BH 6.0

CYE04: CYE03:

Standard: **The Program Contractor ensures that the member and/or member's family are involved in identifying member strengths, needs and decision-making.**
CYE04 Renewal, Section D. ¶12.

Finding(s):
- The Program Contractor does/does not monitor to ensure that the member and/or member's family are involved in needs identification and decision-making.
- The Program Contractor does/does not train case managers and providers in involving the member and his/her family in decision-making and service planning.

Comment(s):

Recommendation(s):

BH 7.0

CYE04: CYE03:

Standard: **The Program Contractor shall ensure that members transferring to the ALTCS program who have previous enrollment with a Regional Behavioral Health Authority are appropriately transitioned.**
CYE04 Renewal, Section D. ¶12.

Finding(s):
- The Program Contractor does/does not coordinate with the Regional Behavioral Health Authority to ensure that members are appropriately transitioned.
- The Program Contractor does/does not ensure that members receive uninterrupted behavioral health services and supports.

Comment(s):

Recommendation(s):

DELIVERY SYSTEM

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

DELIVERY SYSTEMS

STANDARDS	FINDINGS	RECOMMENDATIONS
DS 1.1		
DS 1.2	IO	
DS 2.1		
DS 2.2		
DS 3.0	IO	
DS 4.0		
DS 5.0		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**

NC = Non-Compliance 0-49%
IO = Information Only

DELIVERY SYSTEM

DS 1.0

The Program Contractor has a delivery system that is sufficient to provide all covered services.
CYE04 Renewal, Section D. ¶28-29.

DS 1.1

CYE04: CYE03:

Standard: **The Program Contractor monitors non-provision of HCBS services.**

Finding(s):
- The Program Contractor does/does not have mechanisms to monitor non-provision of authorized HCBS services.
- Action has/has not been taken in response to the results of monitoring non-provision of authorized HCBS services.
- The PC does/does not have a waiting list for HCBS Services.
- The PC does/does not use the waiting list for decisions about network issues.

Comment(s):
Recommendation(s):

DS 1.2

INFORMATION ONLY

Standard: The Program Contractor is doing the following to address the shortage of available home care workers:

Finding(s):
- _____ Salaries
- _____ Benefits
- _____ Enhanced Recruiting
- _____ Mileage
- _____ Cooperative efforts with providers
- _____ Other

Comment(s):
Recommendation(s):

DS 2.0

The Program Contractor's delivery system provides available and accessible services.
CYE04 Renewal, Section D. ¶38.

DS 2.1

CYE04: CYE03:

Standard: **The Program Contractor does/does not ensure that transportation providers meet AHCCCS transportation time standards.**

Finding(s):
- The Program Contractor does/does not ensure that members arrive no sooner than one hour before their scheduled appointment.

Comment(s):
- Action has/has not been taken as a result of monitoring.

Recommendation(s):

DS 2.2

CYE04: CYE03:

Standard: **The Program Contractor assures that a member's waiting time for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency.**

Finding(s):
- The Program Contractor does/does not actively monitor office wait times.
- Office wait times are/are not 45 minutes or less.
- Action has/has not been taken as a result of monitoring.

Comment(s):

Recommendation(s):

DS 3.0 **INFORMATION ONLY**

Standard: The Program Contractor has a process to monitor provider satisfaction with the Program Contractor.

Finding(s):
- The Program Contractor does /does not have a process in place to monitor provider satisfaction.
- The Program Contractor made changes/did not make changes based on results of this monitoring.

Comment(s):
Recommendation(s):

DS 4.0

CYE04: CYE03:

Standard: The Program Contractor incorporates its Member Provider Council feedback in improving its provider network.

CYE04 Renewal, Section D. ¶38.

Finding(s):
- The Program Contractor does /does not discuss its provider network during council meetings.
- The Program Contractor has/has not discussed labor issues at council meetings.
- Action has/has not been taken as the result of council feedback.

Comment(s):
Recommendation(s):

DS 5.0 CYE04: CYE03:

The Program Contractor's shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements.

Standard: **The Program Contractor has sufficient staff to adequately manage the provider network.** CYE04 Renewal, Section D. ¶25.

Finding(s):
- The Program Contractor staff have/have not appropriate training to assist providers in

resolving their issues.

- The Program Contractor does/does not provide appropriate education to its providers regarding the ALTCS Program.

Comment(s):

Recommendation(s):

ENCOUNTERS

AHCCCS REVIEW TEAM:

CONTRACTOR STAFF:

DATE OF REVIEW:

ENCOUNTERS

STANDARDS	FINDINGS	RECOMMENDATIONS
ENC 1.1		
ENC 1.2		
ENC 1.3		
ENC 1.4		
ENC 1.5		
ENC 1.6		
ENC 2.1		
ENC 2.2		
ENC 3.1		
ENC 3.2		
ENC 4.1		
ENC 4.2		

FC = Full Compliance 90-100%

SC = Substantial Compliance 75-89%
PC = Partial Compliance 50-74%
NC = Non-Compliance 0-49%

ENC 1.0

The Contractor shall have in place the organization and administrative systems to ensure the accurate processing and submission to AHCCCSA of encounter data and reports.
CYE04 Renewal, Section D. ¶73-74, Attch C.

ENC 1.1

CYE04: CYE03:

Standard: **The Contractor's difference between expected and observed encounter submission is reasonable.**

Finding(s):
- The Contractor's difference between expected and observed encounter submission is/is not reasonable. For a ten-year period, a ratio of encounter submissions per paid member months are summed and one standard deviation from the mean are computed.

Comment(s):
Recommendation(s):

ENC 1.2

CYE04: CYE03:

Standard: **The Contractor's ratio of encounters submitted by form type per member month is within 2 standard deviations of a two-year mean.**

Finding(s):
- The Contractor's ratio of encounters submitted by form type per member month is/is not within 2 standard deviations of a two-year mean. For a two-year period, a ratio of adjudicated encounters per paid member months is summed and two standard deviations from the overall contractor total mean are computed.

Comment(s):
Recommendation(s):

ENC 1.3

CYE04: CYE03:

Standard: **The Contractor does not unnecessarily delete encounters.**

Finding(s):
- The Contractor does/does not appear to unnecessarily delete encounters. For a two-year period, a ratio of deleted encounters per paid member months are summed and compared to one and two standard deviations from the overall contractor total mean. (Weight of 80%)
- The Contractor does/does not accurately record the number of deleted encounters in the plan's delete logs. A ratio of deleted encounters reported in the delete log per the actual number of deleted encounters is computed. (Weight of 20%).

Comment(s):
Recommendation(s):

ENC 1.4

CYE04: CYE03:

Standard: **The Contractor does not unnecessarily override encounters.**

Finding(s):
- The Contractor does/does not appear to unnecessarily override encounters. For a two-year period, a ratio of overridden encounters per paid member months are summed and compared to one and two standard deviations from the overall contractor total mean. (Weight of 80%)
- The Contractor does/does not accurately record the number of override encounters in the plan's override logs. A ratio of overridden encounters reported in the override log per the actual number of overridden encounters is computed. (Weight of 20%)

Comment(s):
Recommendation(s):

ENC 1.5

CYE04: CYE03:

Standard: **The Contractor reviews encounter data validation results and takes measures to improve complete, timely, and accurate encounter data.**

Finding(s):
- The Contractor reviews encounter data validation results and takes/does not take measures to

improve complete, timely, and accurate encounter data. For both professional and institutional services the percent of error free encounters is computed from the most recent data validation findings.

Comment(s):
Recommendation(s):

ENC 1.6

CYE04: CYE03:

Standard: **The Contractor does/does not submit complete, accurate, and timely encounter data to AHCCCSA.**

Finding(s):
- A sample of Contractor's paid claims is compared to encounters submitted to yield an overall complete, accurate and timely rate.

Comment(s):
Recommendation(s):

ENC 2.0

The Contractor has an administrative system in place to correct the number of pended encounters.
CYE04 Renewal, Attch C.

ENC 2.1

CYE04: CYE03:

Standard: **The Contractor has a reasonable total number of pended encounters.**

Finding(s):
- The Contractor's total number of pended encounters per member month for a two-year average is/is not reasonable. For a two-year period, a ratio of total pended encounters per paid member months are summed and compared to one and two standard deviations from the overall contractor total mean.

Comment(s):
Recommendation(s):

ENC 2.2

CYE04: CYE03:

Standard: **The Contractor has a reasonable number of aged pended encounters.**

Finding(s):
- The Contractor does/does not have a significant number of aged pended encounters greater than 120 days. A ratio of pends greater than 120 days by total pended encounters by paid member months is calculated and compared to one and two standard deviations from the overall contractor total mean.

Comment(s):
Recommendation(s):

ENC 3.0

The Contractor submits adjusted or voided encounter, when claims are adjusted or denied after initial encounter submission.
CYE04 Renewal, Attch C.

ENC 3.1

CYE04: CYE03:

Standard: **The Contractor appropriately submits adjusted encounters.**

Finding(s):
- The Contractor does/does not submit a reasonable number of adjusted encounters. For a two-year period, a ratio of adjusted encounters per paid member months are summed and compared to one and two standard deviations from the overall contractor total mean.

Comment(s):
Recommendation(s):

ENC 3.2

CYE04: CYE03:

Standard: **The Contractor appropriately submits voided encounters.**

Finding(s):
- The Contractor does/does not submit a reasonable number of voided encounters. For a two-year

period, a ratio of voided encounters per paid member months are summed and compared to one and two standard deviations from the overall contractor total mean.

Comment(s):
Recommendation(s):

ENC 4.0

Contractor shall maintain an Encounter Submission Tracking Report (ESTR) and make it available to AHCCCSA upon request. The ESTR's purpose is to link each claim to an adjudicated or pended encounter returned to contractor.
CYE04 Renewal, Section D. ¶74.

ENC 4.1

CYE04: CYE03:

Standard: **The Contractor uses ESTR to link claims to encounters**

Finding(s):
- The Contractor's ESTR does/does not link claims to encounters. By month of service ESTR must include: (1) the number of claims converted monthly to encounters; (2) the number of new day encounters submitted monthly to AHCCCSA; (3) the number of adjudicated and pended encounters returned monthly to contractor; and (4) the percentage of claims converted to encounters.

Comment(s):
Recommendation(s):

ENC 4.2

CYE04: CYE03:

Standard: **The Contractor uses ESTR to track encounter submission volume to AHCCCS and to identify possible omissions.**

Finding(s):
- The Contractor does/does not use ESTR to track encounter submission volume to AHCCCS and to identify possible omissions. Contractor's ESTR contains evidence of trending both encounter submission volume and resolution to aid in identification of possible omissions.

Comment(s):
Recommendation(s):

FINANCIAL MANAGEMENT

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

FINANCIAL MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
FM 1.1		
FM 1.2		
FM 1.3		
FM 2.1		
FM 2.2		
FM 3.0		
FM 4.1		
FM 4.2		
FM 4.3		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**

PC = Partial Compliance 50-74%
NC = Non-Compliance 0-49%

FINANCIAL MANAGEMENT

FM 1.0

Periodic reports are complete, accurate and timely.
CYE04 Renewal, Section D. ¶75.

FM 1.1

CYE04: CYE03:

Standard: **Monthly, quarterly and annual financial reports are complete. These reports include complete disclosure on material variances and or significant changes.**

Finding(s):
- ___ of ___ monthly reports (___%), if required, are complete.
- ___ of ___ quarterly reports (___%)are complete.
- ___ of ___ draft and final audits (___%) are complete.

Comment(s):
Recommendation(s):

FM 1.2

CYE04: CYE03:

Standard: **Quarterly financial reports are accurate when compared to the annual audited financial reports.**

Finding(s):
- Net income does/does not change more than 10% between the 4th Quarterly report and the draft report.

Comment(s):
Recommendation(s):

FM 1.3

CYE04: CYE03:

Standard: **Quarterly and annual financial reports are timely.**

Finding(s):
- All quarterly reports are/are not received within 60 days of quarter end.
- The annual draft audit report is/is not received within 90 days of year end.
- The final audit report is/is not received within 120 days of year end.

Comment(s):

Recommendation(s):

FM 2.0

The Program Contractor meets the required financial viability criteria.
CYE04 Renewal, Section D. ¶52.

FM 2.1

CYE04: CYE03:

Standard: **Per the most recent audit, the current ratio is at least 1%, the equity per member is at least $2,000, the medical expense ratio is at least 85%, the administrative cost percentage is not more than 10% and the received but unpaid days is not more than 30 days.**

Finding(s):
- Current ratio is :
- Equity per member is:
- Medical expense ratio (including case management) is:
- Administrative cost percentage is:
- RBUC's is:

Comment(s):

Recommendation(s):

FM 2.2

CYE04: CYE03:

Standard: **Year to date as of the most recent quarterly report, the current ratio is at least 1%, the equity per member is at least $2,000, the medical expense ratio is at least 85%, the administrative cost percentage is not more than 10% and the received but unpaid days is not more than 30 days.**

Finding(s):
- Current ratio is:
- Equity per member is:
- Medical expense ratio (including case management) is:
- Administrative cost percentage is:
- RBUC's is:

Comment(s):
Recommendation(s):

FM 3.0

The Program Contractor has adequate procedures to ensure that claims are processed by appropriate personnel accurately, timely and with sufficient detail to identify the payment or denial of the claim.
CYE04 Renewal, Section D. ¶44.

CYE04: CYE03:

Standard: **In the absence of a subcontract for different terms, 90% of claims are paid within 30 days and 99% of claims are paid within 90 days of receipt of a clean claim.**

Finding(s):
- ___ of ___ claims reviewed (___%) were paid within 30 days of receipt of a clean claim.
- ___ of ___ claims reviewed (___%) were paid within 90 days of receipt of a clean claim.

Comment(s):
Recommendation(s):

FM 4.0

Program Contractor IBNR Accruals and Pre-payment/Post-payment claims review policies are reasonable.
CYE04 Renewal, Section D. ¶52.

FM 4.1

CYE04: CYE03:

Standard: **IBNR accrual reasonableness review. Based on IBNR reporting for the prior contract year the review will evaluate the accrual versus the payments applied to demonstrate appropriateness. The review will include Institutional, HCBS, and Acute IBNR reporting.**

Finding(s):
- The lag reports do/do not demonstrate appropriateness.

Comment(s):

Recommendation(s):

FM 4.2

CYE04: CYE03:

Standard: **The Program Contractor must have procedures for either pre-payment or post-payment claims review that includes review of supporting documentation. Does the program contractor have approved procedures and policy regarding this requirement.**

Finding(s):
- The program contractor does/does not have on-site approved policies and procedures for pre-payment and post payment claims review.

Comment(s):

Recommendation(s):

FM 4.3

CYE04: CYE03:

Standard: **Program Contractor must have procedures for either pre-payment or post-payment claims review that includes review of supporting documentation.**

Does the program contractor have established procedures regarding any findings from the review.

Finding(s):
- The program contractor does/does not have on-site established policies and procedures for handling findings of the pre and post payment claims review findings.

Comment(s):

Recommendation(s):

GRIEVANCE AND APPEALS

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

GRIEVANCE AND APPEALS

STANDARDS	FINDINGS	RECOMMENDATIONS
GA 1.0		
GA 2.0		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**

GRIEVANCE AND APPEALS

GA 1.0

CYE04: CYE03:

The Program Contractor has written policies for grievances, appeals, and expedited member appeals.
ARS§36-2903.01, AACR9-28-801, 42 CFR 431-438, CYE04 Renewal, Attch B.

Standard: **The Program Contractor has written policies for:**
Member Grievances
Member Appeals
Member Expedited Appeals
Provider Grievances

Finding(s):
- The Program Contractor's written grievance and appeal policies do/do not comply will the Federal Regulations, state statutes and rules, and ALTCS contract requirements.

Comment(s):

Recommendation(s):

GA 2.0

CYE04: CYE03:

The Program Contractor's grievance and appeal decisions are consistent, reliable and relevant to specific grievance issues.
ARS§36-2903.01(B)(4), AACR9-28-801, 42 CFR 431-438, **CYE04 Renewal, Attch B.**

Standard: Each grievance or appeal is thoroughly investigated using the applicable statutory, regulatory and contractual provisions as well as the Program Contractor's policies and procedures, ensuring that facts are gathered from all parties.

Finding(s): A review of _____ grievance decisions reveals that:

- _____ (____%) The Program Contractor timely acknowledged the grievance or appeal.

- _____ (____%) The Program Contractor timely issued a decision.
- _____ (____%) The Program Contractor staff who issue the grievance & appeal decision are not the Medical review was conducted by professionals who had the appropriate clinical expertise not conducted by the included documentation to substantiate the Program Contractor's decision
- _____ (____%) of the decisions stated the nature/issue of the grievance and the reasons supporting the Program Contractor's decision
- _____ (____%) of the decisions included reference to applicable statute, rule, procedure
- _____ (____%) of the decisions stated 15 day appeal rights

Comment(s):
Recommendation(s):

CASE MANAGEMENT

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

CASE MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
CM 1.0		
CM 2.0		
CM 3.0		
CM 4.0	IO	

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**
IO = Information Only

CASE MANAGEMENT

CM 1.0 CYE04: CYE03:

The Program Contractor conducts case management staff orientation/training.
AMPM Chapter 1500, CYE04 Renewal, Section D. ¶16.

Standard: **The Program Contractor must conduct case management orientation/training on subjects relevant to the population served.**

Finding(s):
- The Program Contractor does/does not have a comprehensive orientation program for new case managers.
- The Program Contractor does/does not conduct regular case management trainings on program issues.
- Trainings have/have not included discussion of the ALTCS Guiding Principles, especially involvement of the member and most integrated setting.
- The Program Contractor does/does not train case management staff on their role and responsibility related to monitoring for quality of care.

Comment(s):
Recommendation(s):

CM 2.0 CYE04: CYE 03:

The Program Contractor monitors its case management program.
AMPM Chapter 1500, CYE04 Renewal, Section D. ¶16.

Standard: **The Program Contractor must evaluate its case management program and take appropriate action for improvement.**

Finding(s):
- The Program Contractor does/does not conduct more extensive case file audits for new case managers.
- The Program Contractor does/does not conduct quarterly audits of its case management program.
- The Program Contractor does/does not aggregate and analyze the results of its monitoring process.
- The Program Contractor does/does have an improvement plan to resolve deficiencies identified in

its monitoring process.

Comment(s):
Recommendation(s):

CYE 04: CYE 03:

CM 3.0

The Program Contractor coordinates the appropriate transition and discharge planning of members.
AMPM Chapter 500, 1200 and 1600, CYE04 Renewal, Section D. ¶16.

Standard: **The Program Contractor must have processes in place to assess and coordinate the needs of members involved in a transition or needing discharge planning.**

Finding(s):
- The Program Contractor does/does not have a system in place to ensure appropriate coordination of members transitioning between Program Contractors.
- The Program Contractor does/does not have a system in place to ensure timely and appropriate planning for Transitional Program members in nursing facilities.
- The Program Contractor does/does not have a system in place to ensure case managers are assessing members for the most integrated/least restrictive setting.

Comment(s):
Recommendation(s):

CM 4.0

Information Only

The Program Contractor coordinates appropriate Behavioral Health services for members.
AMPM Chapter 1200, CYE04 Renewal, Section D. ¶16.

Standard: **The Program Contractor coordinates appropriate Behavioral Health services for members.**

Finding(s):
- The Program Contractor does/does not have a standardized process in place to evaluate its members for Behavioral Health reinsurance.

- The Program Contractor does/does not have a process in place to review the continued need for specialized Behavioral Health treatment programs and Reinsurance for its members.
- The Program Contractor has/has not provided education to its high cost Behavioral Health placement providers regarding documentation of treatment plans.

Comment(s):
Recommendation(s):

CASE MANAGER INTERVIEW

1. **Describe your process related to a newly enrolled member (including one transitioning from another PC), beginning with initial contact and the assessment of needs through the arrangement for services and any follow-up. Does your program have a system of triage for new members?**

2. **Describe how you approach the issue of cost effectiveness and explain this to members/representatives.**

3. **Describe what actions you take when a member requests a service (covered or not), including what steps you would take if the service was not available as requested.**

4. **Describe how you assess institutionalized members for potential discharge to HCBS and what actions you take when HCBS is determined to be appropriate for the member.**

5. **How many cases do you currently have assigned? Do you feel you have adequate time to devote to all your assigned members? What, if anything, would you like to see done differently with regard to caseload assignments?**

QUALITY MANAGEMENT

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

QUALITY MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
QM 1.1		
QM 1.2		
QM 2.1		
QM 2.2		
QM 3.1		
QM 3.2		
QM 4.0		

STANDARDS	FINDINGS	RECOMMENDATIONS
QM 5.0		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**

QUALITY MANAGEMENT

QM 1.0

Quality Management/Quality Improvement (QI/QM) Program Scope.
AMPM Chapter 900, Policy 920

QM 1.1

CYE 04: CYE 03:

Standard: **The QM/QI Program must have components that incorporate care coordination.**

Finding(s):
- The Contractor did/did not implement a process to ensure that a "best effort" attempt has been made to conduct an initial assessment of each member's health care needs.
- The Contractor does/does not have measures to ensure that members are informed of specific health care needs that require follow-up.

Comment(s):
Recommendation(s):

QM 1.2

CYE 04: CYE 03:

Standard: **The QM/QI Program scope must incorporate monitoring and evaluation activities, and must**

demonstrate how these activities will improve the quality of services and the continuum of care in all service sites
21.

Finding(s):

- There is/is not evidence that the Contractor monitors all services and service sites which must include, but are not limited to, Home and Community Based services as follows: (Score each of the following separately)
  - Attendant Care
  - Habilitation (if applicable)
  - Homemaker
  - Home Health Services (non-Medicare)
  - Personal Care
  - Respite
  - Transportation

Comment(s):
Recommendation(s):

QM 2.0

Credentialing and Recredentialing Processes.

AMPM Chapter 900, Policy 950

QM 2.1

CYE 04: CYE 03:

Standard: The Contractor must have a system in place for credentialing and recredentialing providers included in their contracted service provider network. ***Not applicable if the Program Contractor has achieved accreditation.***

Finding(s):

- The Contractor does/does not recredential providers at least every three years.
- Performance monitoring data is/is not included in the recredentialing decision-making process

for primary care practitioners. This must include at a minimum:

Member complaint information and
Information from quality improvement activities.

- The policies do/do not reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee
- The Contractor has been found to be _____ percent compliant with AMPM requirements after review of _____ credentialing/recredentialing charts.

Comment(s):
Recommendation(s):

QM 2.2

CYE 04: CYE 03:

Standard: **The Contractor must have written policies that reflect the scope, criteria, timeliness and process for credentialing and recredentialing practitioners and organizational providers.** *Not applicable if the Program Contractor has achieved accreditation.*

Finding(s):

- The Contractor does/does not have credentialing/recredentialing policies and procedures reviewed and approved by the Contractor's executive management.
- The Contractor does/does not have policies and procedures that address denial, suspension or termination of privileges, or the reduction of privileges, for a contracted provider. An appeals process, and the mechanism to inform the provider about the appeals process, must be included.
- The Contractor does/does not have procedures that address the initial credentialing process.
- The Contractor does/does not have procedures that address the recredentialing process.
- For organizational providers included in its network (hospitals, nursing facilities, behavioral health residential treatment facilities, surgi-centers, etc.) the Contractor does/does not validate

and re-validate at least every three years, that the provider:

- Is licensed to operate in the state, and is in compliance with any other applicable State or Federal requirements.
- Is reviewed and approved by an appropriate accreditation body or is determined by the Contractor to meet standards established by the organization itself.

Comment(s):
Recommendation(s):

QM 3.0

Abuse/Complaint Tracking and Trending.

AMPM Chapter 900, Policy 960

QM 3.1

CYE 04: CYE 03:

Standard: **Each Contractor must have a process for reviewing and evaluating complaints and allegations.**

Finding(s):

- The Contractor has been found to be _____percent compliant with AMPM requirements after review of _____ Quality of Care charts.

Comment(s):
Recommendation(s):

QM 3.2

CYE 04: CYE 03:

Standard: **Each Contractor must develop procedures, policies, and processes for resolving issues raised by enrolled members and contracted providers.**

Finding(s):

- The Contractor has/has not developed an action plan to reduce/eliminate the likelihood of a complaint/abuse issue reoccurring
- The Contractor has/has not determined and implemented appropriate interventions.
- The Contractor did/did not monitor the success of interventions developed as a result of member complaint/abuse

issues.

- The Contractor did/did not incorporate successful interventions into the QM program or assign new interventions/approaches when necessary.

Comment(s):
Recommendation(s):

QM 4.0

CYE04: CYE03:

Performance Indicators

(AMPM Chapter 900, Policy 970, Page 970-1; CYE 04 Renewal, Paragraph 20)

Standard: The Quality Management/Quality Improvement (QM/QI) Program must report the performance of the Contractor using standard performance indicators established or adopted by AHCCCS

Finding(s):

- The Contractor did/did not report their performance using standard performance indicators established or adopted by AHCCCS.
- The Contractor did/did not achieve at least Minimum Performance Standards established by AHCCCS.
- The Contractor did/did not show demonstrable and sustained improvement toward meeting all goals for Indicator quality improvement established by AHCCCS.
- The Contractor did/did not develop and implement a corrective action plan to bring the performance up to at least the minimum level established by AHCCCS.

Comment(s):
Recommendation(s):

QM 5.0

CYE04: CYE03:

Quality Improvement Projects (QIPs)/Performance Improvement Projects (PIPs) –Selection and Assessment.

AMPM Chapter 900, Policy 980

Standard: Each Contractor must conduct Quality Improvement Projects (QIPs)/Performance Improvement Projects (PIPs) to assess the quality of its service provision and improve performance.

Finding(s):

- The Contractor has/has not designed QIP/PIPs to achieve correction of significant problems that come to the attention of the Contractor through one or more of the following:
  - Internal surveillance and service delivery monitoring
  - Credentialing/recredentialing
  - Tracking and trending of complaints/allegations
  - Member and/or provider satisfaction surveys
  - Other mechanisms
- The Contractor has/has not initiated interventions that result in significant demonstrable and sustained improvement in its performance. (980-7-a)
- After completing the second year of the QIP/PIP, the Contractor has/has not submitted a report evaluating the success of the interventions and resulting improvement in the quality of care. (980-8-c)
- If the QIP/PIP interventions did not result in demonstrable improvement, the Contractor has/has not proposed actions to revise/replace interventions and/or initiate new measurement indicators to improve quality of care. (980-8-end statement)

Comment(s):

Recommendation(s):

UTILIZATION MANAGEMENT

ALTCS AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

UTILIZATION MANAGEMENT

STANDARDS	FINDINGS	RECOMMENDATIONS
UM 1.1		
UM 1.2		
UM 1.3		
PA 1.1		
PA 1.2		
PA 1.3		
PA 1.4		

STANDARDS	FINDINGS	RECOMMENDATIONS
CR 1.1		
CR 1.2		
CA 1.0		

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**

UM 1.0 The ALTCS Contractor has a structure and process in place to monitor and evaluate utilization of services.
CYE 04 Renewal, AMPM Ch.1000

UM 1.1 CYE 04 CYE 03

Standard: The Contractor has written policies and procedures for utilization management program requirements which are consistent with AHCCCS standards.

Finding(s): The Contractor does/does not have written processes, policies and procedures in place for monitoring and evaluating utilization of services.

Comment(s):

Recommendation(s):

UM 1.2 CYE 04 CYE 03

Standard: **Mechanisms are in place to identity and address potential under and over-utilization issues**.

Finding(s):
- Processes are/are not in place to detect potential HCBS under-utilization issues.
- Action is/is not taken when potential HCBS under-utilization issues are identified.
- Action is/is not taken when potential over-utilization issues related to managing Emergency Department utilization are identified.

Comment(s):

Recommendation(s):

UM 1.3 CYE 04 CYE 03

Standard: **The Contractor has adopted and disseminated practice guidelines.**

Finding(s):
- The Contractor does/does not have established practice guidelines.
- The Practice Guidelines are/are not based on recognized national or community standards.
- The Contractor has/has not distributed the practice guidelines to providers.

Comment(s):

Recommendation(s):

PA 1.0

The ALTCS Contractor has a structure and process in place for the prior authorization of requested medical services. CYE 04 Renewal, AMPM Ch. 1000

PA 1.1	CYE 04	CYE 03
Standard:	The Contractor has a structure and process in place to monitor/evaluate prior authorization services.	

Finding(s):
- The Contractor does/does not utilize standardized criteria when making PA decisions.
- The Contractor does/does not have written policies regarding prior authorization inter-rater reliability.
- Monitoring processes are/are not in place to evaluate the consistency with which individuals involved in PA decision making apply the established criteria.
- Action is/is not taken when criteria are not being applied in a consistent manner by the PA staff.
- The Contractor Medical Director or physician designee does/does not review and sign all PA denial decisions.

Comment(s):

Recommendation(s):

PA 1.2	CYE 04	CYE 03
Standard:	**The Contractor makes prior authorization decisions in a timely manner.**	

Finding(s):
- The Contractor does/does not have appropriate timelines for making the initial prior authorization decision.
- Processes are/are not in place to evaluate the timeliness of the initial PA decision.
- Action is/is not taken when timeframes for making the initial decision are not being met.

Comment(s):

Recommendation(s):

PA 1.3

CYE 04 CYE 03

Standard: **The Contractor monitors summary information that describes the cost and utilization of pharmacy services to allow the Contractor to adequately manage its prescription benefit program.**

Finding(s): The Contractor does/does not monitor pharmacy cost and utilization data.
The Contractor does/does not have criteria in place for the review of requests for non-formulary medications.
The Contractor does/does not have established timelines for making the initial decision regarding requests for non-formulary medications.
Processes are/are not in place to evaluate compliance with the established timelines for making the initial decision for non-formulary medications.
The Contractor Medical Director or physician designee does/does not review and sign all PA pharmacy denial decisions.

Comment(s):

Recommendation(s):

PA 1.4 Information Only
Standard: The Contractor utilizes a Pharmacy Benefit Manager.

Finding(s):
- The Contractor does/does not utilize a Pharmacy Benefit Manager.

Comment(s):

Recommendation(s):

CR 1.0

The ALTCS Contractor has an effective concurrent review process.
CYE 03, AMPM Ch. 1000

CR 1.1 CYE 04 CYE 03

Standard: The Contractor has a process in place for reviewing the medical necessity of inpatient stays.

Finding(s): The Contractor does/does not utilize standardized criteria for length of stay determinations.
The Contractor does/does not have policies to describe what relevant clinical information is to be obtained when making hospital length of stay decisions.
Processes are/are not in place to evaluate the consistency with which individuals involved in decision making apply the criteria.
Action is/is not taken when criteria are not being applied in a consistent manner.

Comment(s):

Recommendation(s):

CR 1.2 Information Only

Standard: **The Contractor has a process in place to conduct Concurrent Review on-site or telephonically.**
(CYE 04 Contract, AMPM Ch. 1000)

Finding(s):
- The Contractor does/does not have a process in place to conduct Concurrent Review on-site or telephonically.

Comment(s):

Recommendation(s):

CA 1.0 The ALTCS Contractor promotes continuity and coordination of care when appropriate.
CYE 04 Renewal, AMPM Ch.1000

CYE 04 CYE 03

Standard: **The Contractor ensures that at risk members have care coordination/case management services available**

Finding(s):

- The Contractor has/has not implemented processes related to Disease Management.
- The Contractor has/has not implemented processes related to Transplant procedures.
- The Contractor does/does not have a process in place for coordination of care for members who transition to another program contractor or to acute care.

Comment(s):

Recommendation(s):

MEDICAL DIRECTION

AHCCCS REVIEW TEAM:

PROGRAM CONTRACTOR STAFF:

DATE OF REVIEW:

MEDICAL DIRECTION

STANDARDS	FINDINGS	RECOMMENDATIONS
MD 1.0	IO	Information Only
MD 2.1	IO	Information Only
MD 2.2	IO	Information Only
MD 3.0	IO	Information Only
MD 4.0	IO	Information Only
MD 5.1	IO	Information Only
MD 5.2	IO	Information Only

FC = Full Compliance **90-100%**
SC = Substantial Compliance **75-89%**
PC = Partial Compliance **50-74%**
NC = Non-Compliance **0-49%**
IO = Information Only

MEDICAL DIRECTION

MD 1.0

The Medical Director is responsible for oversight of provider recruitment activities.
CYE04 Renewal, Section D. ¶27.

MD 1.0

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director is actively involved in the provider relations process, including recruitment and retention as well as providing/participating in ongoing program updates and training with contracted providers.**

Finding(s):
- The Medical Director is/is not actively involved in the recruitment and retention of providers.
- The Medical Director does/does not provide and participate in ongoing program updates and training with contracted providers.

Comment(s):

Recommendation(s):

MD 2.0

The Medical Director is responsible for the administration of all medical activities of the program contractor.
CYE04 Renewal, Section D. ¶27.

MD 2.1

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director has a clearly defined role in the day-to-day clinical as well as non-clinical aspects of the organization's operations.**

Finding(s):
- The Medical Director does/does not have a clearly defined role in the day-to day clinical aspects of the organizations operations.
- The Medical Director does/does not have a clearly defined role in the day-to day non-clinical aspects of the organizations operations.

Comment(s):

Recommendation(s):

MD 2.2

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director is directly involved in working with program contractor staff on treatment planning/placement decisions for members with complex health conditions, especially members with complex behavioral health needs who are difficult to manage in traditional settings.**

Finding(s):
- The Medical Director is/is not involved in working with staff on treatment planning decisions for members with complex health conditions, especially members with complex behavioral health needs.
- The Medical Director is/is not actively involved in the review of out of state placement requests, including attempts to find and/or develop appropriate in-state placements.

Comment(s):
Recommendation(s):

MD 3.0

The Medical Director is responsible for the development, implementation, and medical interpretation of medical policies and procedures to guide and support the provision of medical care to members.
CYE04 Renewal, Section D. ¶27.

MD 3.0

CYE04: Information Only CYE03: N/A

Standard: **A well defined process exists that includes the Medical Director in the development and review of policies and procedures, quality and utilization management activities, credentialing and re-credentialling, as well as the quality improvement projects and interventions associated with these activities..**

Finding(s):
- A well-defined process does/does not exist that includes the Medical Director in the development and review of policies and procedures.
- A well-defined process does/does not exist that includes the Medical Director in quality and utilization management activities.

- A well-defined process does/does not exist that includes the Medical Director in the credentialing and re-credentialling process.
- A well-defined process does/does not exist that includes the Medical Director in quality improvement projects.

Comment(s):
Recommendation(s):

MD 4.0

The Medical Director is responsible for continuous assessment and improvement of the quality of care provided to members (e.g. quality of care issues, quality indicators, annual medical study).
CYE04 Renewal, Section D. ¶27.

MD 4.0

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director is directly involved in the AHCCCS performance indicators and Performance Improvement Projects (PIPs) (formerly referred to as Quality Improvement Projects) including analysis of internal and AHCCCS data, determination, implementation, and review of effectiveness of strategies put in place to improve rates, and development and ongoing monitoring of PIPs.**

Finding(s):
- The Medical Director is/is not directly involved in data analysis for PIPs.
- The Medical Director is/is not directly involved in determination, implementation, and review of the effectiveness of strategies put in place to improve rates.
- The Medical Director is/is not directly involved in development and ongoing monitoring of program contractor PIPs.

Comment(s):
Recommendation(s):

MD 5.0

The Medical Director is responsible for oversight of medical provider profiling, including utilization management activities.
CYE04 Renewal, Section D. ¶27.

MD 5.1

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director is actively involved in oversight of program activities related to over/under utilization of services.**

Finding(s):
- The Medical Director is/is not directly involved in oversight of program activities related to over/under utilization of services.

Comment(s):
Recommendation(s):

MD 5.2

CYE04: Information Only CYE03: N/A

Standard: **The Medical Director directly participates in an ongoing process to review program contractor Prior Authorization (PA) guidelines and to ensure consistent and timely application of the PA criteria..**

Finding(s):
- The Medical Director does/does not directly participate in an ongoing process to review program contractor Prior Authorization (PA) guidelines and to ensure consistent and timely application of the PA criteria.

Comment(s):
Recommendation(s):

ANALYSIS OF CORRECTIVE ACTION PLAN FROM PREVIOUS REVIEW

Appendix C

Documents Reviewed List

AHCCCSA Materials Reviewed by Mercer

- ALTCS Elderly and Physically Disabled Contract for CY 10/10/03 through 9/30/04
- AHCCCS Member Handbook Checklist
- AHCCCS Network Management and Development Plan Checklist
- AHCCCS EQRO Mapping Crosswalk (for each Contractor)
- AHCCCS ALTCS Operational and Financial Review for CYE 2004 (for each Contractor)
- AHCCCS Member Handbook Approval Notice (for each Contractor)
- AHCCCS Network Management and Development Plan Approval Notice (for each Contractor)
- ALTCS Member Materials Approval Notice (for each Contractor)
- CYE 2004 ALTCS/EPD Contract, § D-20 & Contract Attachment, Periodic Reporting Requirements
- CYE 2004 ALTCS/DDD Contract, § D-20 & Contract Attachment, Periodic Reporting Requirements
- AMPM Policy 980 & Policy 990
- AHCCCS Clinical QM Unit Annual QM Plan & Evaluation Review Tool
- CYE 2004 ALTCS/EPD Contract, § D-20
- CYE 2004 ALTCS/DDD Contract, § D-20
- AMPM Policy 980 PIPs – Selection & Assessment
- AHCCCS CYE 2004 PIP Topic Ranking Matrix & Rationale
- CYE 2004 ALTCS PIP Methodology: Management of Co morbid Diseases
- Internal & External Data/Trend Information Used in Selection Process of CYE 2005 ALTCS PIP
- Communication with Contractors Regarding CYE 2005 ALTCS PIP
- Subsequent Communication Regarding CYE 2005 ALTCS PIP
- AMPM Policy 980, PIPs — Selection & Assessment
- ALTCS Performance Measure & PIP Quality Control Process
- AHCCCS Study Validation Process
- CYE 2003 PIP Baseline Measurement Rates by ALTCS Contractors & DDD
- CYE 2003 PIP Report
- Communication with ALTCS Contractors Regarding CYE 2003 PIP
- CYE 2002 PIP Baseline Measurement: Rates by ALTCS Contracts and DDD
- CYE 2002 PIP Report
- CYE 2002 PIP Remeasurement Data: Rates by ALTCS Contractors & DDD

- Communication with ALTCS Contractors Regarding PIP Reporting & Interventions
- CYE 2004 OFR Tools for QM Standard 5.0
- CYE 2004 ALTCS/EPD Contract, § D-20
- CYE 2004 ALTCS/DDD Contract, § D-20
- AMPM Policy 970 — Performance Indicators
- AHCCCS Clinical QM Unit Annual QM Plan & Evaluation Review Tool
- CYE 2004 OFR Tools for QM Standard 4.0
- CYE 2004 OFR Tools for Encounter Standards
- AHCCCS Encounter Validation Technical Document
- AHCCCS Summary Report of Encounter Data Validation Studies for CYE 2001
- ALTCS Performance Measure & PIP Quality Control Process
- Mercy Care Plan CYE 2004 QM Plan & CYE 2003 QM Evaluation
- AHCCCS Letter to Mercy Care Plan LTC Approving its CYE 2004 QM Plan & CYE 2003 Evaluation
- Mercy Care Plan CYE 2004 QM Plan & CYE 2003 QM Evaluation — PIPs
- AHCCCS Communication with Mercy Care Plan LTC Regarding its PIP Results
- Mercy Care Plan LTC Results for CYE 2004
- OFR QM Standards, including PIPs
- Mercy Care Plan CYE 2004 QM Plan & CYE 2003 Evaluation — Performance Measures
- AHCCCS Reported Results of CYE 2004 Performance Measures for Mercer Care Plan LTC
- Mercy Care Plan LTC Corrective Action Plan for Diabetes Measures and related Correspondence
- Mercy Care Plan LTC Results for CYE 2004 OFR Standard Regarding Performance Measures
- Mercy Care Plan LTC Results for CYE 2004 OFR Encounter Standards
- AHCCCS Encounter Data Validation Studies — Mercy Care Plan LTC Results
- Mercy Care Plan CYE 2004 UM Plan & CYE 2003 Evaluation
- AHCCCS Letter to Mercy Care Plan LTC Approving its CYE 2004 UM Plan & CYE 2003 Evaluation
- Mercy Care Plan LTC Results for CYE 2004 UM OFR Standards
- Mercy Care Plan LTC Results for CYE 2004 QM OFR Standards — Special Needs Members
- Cochise Health Systems CYE 2004 QM Plan & CYE 2003 QM Evaluation
- Letter to Cochise Health Systems Regarding CYE 2004 QM Plan & CYE 2003 Evaluation
- Cochise Health Systems CYE 2004 QM Plan — PIPs
- AHCCCS Communication with Cochise Health Systems Regarding its PIP Results

- Cochise Health Systems OFR Results for
- CYE 2004 QM Standards, Including PIPs
- Cochise Health Systems CYE 2004 QM Plan & CYE 2003 QM Evaluation — Performance Measures
- Cochise Health Systems Results for CYE 2004 OFR Standard Regarding Performance Measures
- AHCCCS Reported Results of Performance Measures for Cochise Health Systems in CYE 2004
- AHCCCS Letter Requesting Corrective Action Plan for Diabetes Performance Measures
- Cochise Health Systems Results for CYE 2004 OFR Encounter Standards
- AHCCCS Encounter Data Validation Studies — Cochise Health Systems
- Cochise Health Systems CYE 2004 UM Plan & CYE 2003 Evaluation
- AHCCCS Letter Approving Cochise Health Systems CYE 2004 UM Plan and CYE 2003 Evaluation
- Cochise Health System Results for CYE 2004 UM OFR Standards
- Cochise Health Systems Results for CYE 2004 QM OFR Standards — Special Needs Members
- Evercare Select CYE 2004 QM Plan & CYE 2003 QM Evaluation
- Letters to Evercare Select Regarding CYE 2004 QM Plan & CYE 2003 Evaluation
- Evercare Select CYE 2004 QM Plan — PIPs
- AHCCCS Communication with Evercare Select Regarding PIP Results
- Evercare Select OFR Results for CYE 2004 QM Standards, including PIPs
- Evercare Select CYE 2004 QM Plan & Work Plan — Performance Measures
- AHCCCS Reported Results of Performance Measures for Evercare Select in CYE 2004
- AHCCCS Letter Requesting Corrective Action Plan for HCBS Performance Measures
- CAP Response from Evercare Select Regarding HCBS Performance Measure, AHCCCS Response
- Evercare Select Results for CYE 2004 OFR Standard regarding Performance Measure
- Evercare Select Results for CYE 2004 OFR Encounter Standards
- AHCCCS Encounter Data Validation Studies for CYE 2001 — Evercare Select Results
- Evercare Select CYE 2004 UM Plan & CYE 2003 Evaluation
- AHCCCS Letter Approving Evercare Select CYE 2004 UM Plan & CYE 2003 Evaluation
- Evercare Select Results for CYE 2004 UM OFR Standards
- Evercare Select Results for CYE 2004 QM OFR Standards 1.1 & 1.2
- Pima Health System LTC CYE 2004 QM Plan, CYE 2003 QM Evaluation & CYE 2004 Work Plan
- Letter to Pima Health System LTC Regarding CYE 2004 QM/PI Plan & CYE 2003 Evaluation
- Pima Health System LTC CYE 2004 QM/PI Plan, Work Plan & CYE 2003 Evaluation — PIPs

- AHCCCS Communication with Pima Health System LTC Regarding its PIP Results
- Pima Health System LTC Results for CYE 2004 QM Standards, including PIPs
- Pima Health System LTC CYE 2004 QM/PI Plan & Work Plan — Performance Indicator
- AHCCCS Reported Results of CYE 2004 Performance Measures for Pima Health System LTC
- Pima Health System LTC Results for CYE 2004 OFR Standard Regarding Performance Measures
- Pima Health System LTC Results for CYE 2004 OFR Encounter Standards
- AHCCCS Encounter Data Validation Studies — Pima Health System LTC Results
- Pima Health System LTC CYE 2004 UM Plan & CYE 2003 Evaluation
- AHCCCS Letter Regarding Pima Health System LTC CYE 2004 UM Plan & Evaluation
- Pima Health System LTC Results for CYE 2004 OFR UM OFR Standards
- Pima Health System LTC Results for CYE 2004 QM Standards 1.1 & 1.2
- Pinal/Gila LTC CYE 2004 QM Plan & CYE 2003 Evaluation
- Letter to Pinal/Gila LTC Regarding its CYE 2004 QM Plan & CYE 2003 Evaluation
- Pinal/Gila LTC CYE 2004 QM Plan & CYE 2003 Evaluation — PIP
- AHCCCS Communication with Pinal/Gila LTC Regarding its PIP Results
- Pinal/Gila LTC OFR Results for CYE 2004 QM Standards, including PIPs
- Pinal/Gila LTC CYE 2004 QM Plan & CYE 2003 Evaluation — Performance Measure
- AHCCCS Reported Results of CYE 2004 Performance Measures for Pinal/Gila LTC
- Pinal/Gila LTC Results for CYE 2004 OFR Standard Regarding Performance Measures
- Pinal/Gila LTC Results for CYE 2004 OFR Encounter Standard
- AHCCCS Encounter Data Validation Studies — Pinal/Gila LTC Results
- Pinal/Gila LTC CYE 2004 UM Plan & CYE 2003 Evaluation
- AHCCCS Letter Approving Pinal/Gila LTC CYE 2004 UM Plan & CYE 2003 Evaluation
- Pinal/Gila LTC Results for CYE 2004 OFR UM OFR Standards
- Pinal/Gila LTC Results for CYE 2004 QM Standards 1.1 & 1.2
- Yavapai County LTC CYE 2004 QM/UM Plan & 2003 QM/UM Evaluation
- Letter to Yavapai County LTC Regarding CYE 2004 QM Plan & CYE 2003 Evaluation
- Yavapai County LTC CYE 2004 QM/UM Plan, Work Plan & CYE 2003 Evaluation — PIP
- AHCCCS Communication with Yavapai County LTC Regarding its PIP Results
- Yavapai County LTC OFR Results for CYE 2004 QM Standards, including PIPs
- Yavapai County LTC CYE 2004 QM/UM Plan & Work Plan — Performance Indicators

- AHCCCS Reported Results of CYE 2004 Performance Measures for Yavapai County LTC
- Yavapai County LTC Results for CYE 2004 OFR Standard Regarding Performance Measures
- Yavapai County LTC Results for CYE 2004 OFR Encounter Standard
- AHCCCS Encounter Data Validation Studies CYE 2001 — Yavapai County LTC Results
- Yavapai County LTC CYE 2004 QM/UM Plan & Work Plan, CYE 2003 Evaluation
- AHCCCS Letter Regarding Yavapai County LTC CYE 2004 QM/UM Plan & Evaluation
- Yavapai County LTC Results for CYE 2004 UM OFR Standards
- Yavapai County LTC Results for CYE 2004 QM OFR Standards 1.1 & 1.2

MERCER

Government Human Services Consulting

Mercer Government Human Services Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500